

ANCIENT REMEDIES, NEW DISEASE:



*Involving traditional
healers in increasing
access to AIDS care
and prevention
in East Africa*



Joint United Nations Programme on HIV/AIDS

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Abbreviations

AIDS	Acquired immunodeficiency syndrome
BHP	Biomedical health practitioner
CBO	Community-based organization
CHICC	Community Health Information and Care Centre (Tanzania)
FGD	Focus group discussion
HIV	Human immunodeficiency virus
IEC	Information, education and communication
KANCO	Kenya AIDS NGO Consortium
KEFRI	Kenya Forestry Research Institute
KEMRI	Kenya Medical Research Institute
KITHETA	Kiboga THETA (Uganda)
NACP	National AIDS Control Programme (Tanzania and Uganda)
NACC	National AIDS Control Council (Kenya)
NGO	Nongovernmental organization
MoH	Ministry of Health
PLWHA	People living with HIV/AIDS
SHDEPHA+	Service Health and Development for People with HIV/AIDS (Tanzania)
STDs	Sexually transmitted diseases
STIs	Sexually transmitted infections
TAWG	Tanga AIDS Working Group (Tanzania)
TASO	The AIDS Support Organisation (Uganda)
TB	Tuberculosis
TBA	Traditional birth attendants
THETA	Traditional and Modern Health Practitioners together against AIDS and other diseases (Uganda)
THECA	Traditional Healers, Educators and Counsellors on AIDS Awareness (Uganda)
TH	Traditional healer
UNICEF	United Nations Children's Fund
UNAIDS	Joint United Nations Programme on HIV/AIDS
WOFAK	Women Fighting AIDS in Kenya

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Foreword

Scaling up AIDS efforts in Africa is crucial, and requires the participation of all social and economic sectors. As frequently noted at the 2001 International Conference on AIDS in Africa, scaling down disease can only take place by scaling up resources. One abundant and relatively untapped resource for an expanded response to the AIDS epidemic is the traditional sector. In Africa, pioneer programmes and empowered communities have demonstrated to the world the importance of local responses to HIV/AIDS.

In countries where resources are limited, the principles of primary health care demand that all available, accessible, acceptable and affordable resources be applied towards the health of the people. The AIDS epidemic forces us to renew our interest in these principles, partly because of desperate and overwhelming needs, but also because of the imperative to seek diverse solutions that are embedded within the cultural and environmental milieux.

Traditional healers make a unique contribution that is complementary to other approaches. They also tend to be the entry point for care in many African communities, and even more so for the complex HIV-related diseases that frequently jolt family dynamics and shake community stability. Traditional healers often have high credibility and deep respect among the population they serve. They are knowledgeable about local treatment options, as well as the physical, emotional and spiritual lives of the people, and are able to influence behaviours. Thus, it is imperative and practical to consider traditional healers as partners in the expanded response to HIV/AIDS, and to maximize the potential contribution that can be made towards meeting the magnitude of needs for care, support and prevention.

To this end, best practices from the traditional sector were identified in three countries of East Africa: Kenya, the United Republic of Tanzania and Uganda. Three specific programmes exhibited an enormous capacity for care and influence on the part of traditional healers, and for creating a wider and more comprehensive response, as well as for embracing traditional healers as part of the solution to HIV/AIDS in the African context.

There is an urgency to act now. We know that the HIV/AIDS challenge cannot be met without new resources. Furthermore, it cannot be met without consideration for the contribution from the old and trusted traditional sector. *Ancient Remedies, New Disease* provides motivation and inspiration through the sharing of experiences and innovative approaches to tackling the new challenges of HIV/AIDS with both new and old resources to increase access to HIV/AIDS care and prevention.

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I. INTRODUCTION

"The disease is all around us—within our community, our families, our houses—and it will defeat our best efforts at peace and development unless we defeat it first."

Kofi Annan, UN Secretary General

In the 20 years that it has been with us, AIDS has continued its relentless spread across continents. By the end of 2000, the United Nations Joint Programme on HIV/AIDS (UNAIDS) reported that 36.1 million men, women and children were living with HIV around the world and 21.8 million had died. Though AIDS is now found in every country, it has most seriously affected sub-Saharan Africa—home to 70% of all adults and 80% of all children living with HIV, and the continent with the fewest medical resources in the world.

AIDS is now the primary cause of death in Africa and it has had a devastating impact on villages, communities and families on the continent. In many African countries, the numbers of new infections are increasing at a rate that threatens to destroy the social fabric. Life expectancies are decreasing rapidly in many of these countries as a result of AIDS-related illnesses and socioeconomic hardships. And of the 13.2 million children orphaned by HIV/AIDS worldwide, 12.1 million are in Africa.

In the past, AIDS-control activities relied on giving information about HIV transmission, and imparting practical skills to enable individuals to reduce their risk of HIV infection and care for themselves if infected. There is a growing awareness, however, that sociocultural factors surrounding the individual need to be considered in designing both prevention and care interventions. As the epidemic continues to ravage the low- and middle-income world, it becomes increasingly evident that diverse strategies to confront the wide-ranging and complex social, cultural, environmental and economic contexts in which HIV continues to spread must be researched, tested, evaluated, adapted and adopted.

Today, in 2002, interventions to stem the spread of HIV worldwide are as varied as the contexts in which we find them. Not only is the HIV epidemic dynamic in terms of approaches to treatment, prevention strategies and disease progression, but sexual behaviour, which remains the primary target of AIDS-prevention efforts worldwide, is widely diverse and deeply embedded in social and cultural relationships, as well as environmental and economic processes. This makes the prevention of HIV very complex. In addition, care for people infected with HIV depends not only on the local health infrastructure of the country or village, but on social and family structures, beliefs, values and economic conditions.

Monitoring and evaluation of prevention programmes have shown that prevention does work. In countries that have quickly implemented well-planned programmes with support from political and religious leaders, HIV prevalence has been kept consistently low, and has even decreased in some countries in the last five years (UNAIDS, 1998). Yet, cases of decreased HIV prevalence are still the exception and many developing countries are struggling to find innovative, cost-effective strategies that are relevant to the status of the epidemic in their nation. Especially in countries where prevalence and incidence of HIV are still climbing rapidly, as well as in those countries where morbidity and mortality associated with HIV are alarmingly high, AIDS programme leaders are searching for creative solutions to increase access to both prevention and care services.

Pioneering programmes in Africa have demonstrated to the world the importance of local responses to HIV/AIDS, which aim to empower communities through local partnerships consisting of social groups, service providers and facilitators. Effective community-centred efforts have generally been both empowering, i.e. strengthening a community's capacity to make decisions, and enabling, assisting communities in mobilizing the resources required for them to act on those decisions.

In countries such as Kenya, the United Republic of Tanzania or Uganda, where resources are limited, there is a desperate need for care, support and prevention alternatives that are readily available, accessible and affordable, given the vast number of people who do not have access to government health units or hospitals. And, given the stigma associated with HIV/AIDS in many

African communities, to be viable, these alternatives must take into consideration the feelings of patients, their ability/inability to pay for the health services and their sociocultural and economic realities. Traditional medicine is one such alternative.

II. TRADITIONAL MEDICINE AND AIDS IN SUB-SAHARAN AFRICA—HISTORY AND TERMINOLOGY

Traditional healing practices existed in Africa long before conventional medicine, and attempts by colonial governments and early religious missionaries to suppress it did not succeed. As an untapped reservoir of knowledge, philosophy and history, traditional medicine not only offers the possibility of cures, but it also provides a national heritage and a means of linking the land and its people.

In sub-Saharan Africa today, traditional healers far outnumber modern health practitioners, and the majority of the population uses traditional medicine. WHO estimates that 80% of people in low- and middle-income countries rely primarily on traditional medicine for their primary health-care needs. Although the actual number of traditional healers is unknown in most countries, such healers constitute a significantly large group of practitioners who are recognized, trusted and respected by their respective communities.

Traditional healers provide client-centred, personalized health care that is tailored to meet the needs and expectations of their patients. This makes them strong communication agents for health and social issues. They have greater credibility than do village health workers, especially with respect to social and spiritual matters. They, thus, make valuable supporters and implementers of development initiatives. In resource-constrained settings, traditional medicine provides access to treatment where expensive imported pharmaceuticals cannot. Moreover, in some contexts, traditional medicine has been found to be as effective as biomedical treatment, if not more so, in treating HIV-associated opportunistic infections such as herpes zoster and chronic diarrhoea (Homsy, 1999).

There has been much scepticism surrounding traditional medicine and traditional healing practices in the last four decades. This document is an attempt to shed light on the complex nature of traditional medicine and its prominent role in disease prevention and care that began centuries before the advent of modern medicine.

Traditional medicine in East Africa

The majority of populations in East Africa have access to only traditional health care. Traditional healers are well known in their communities for their expertise in treating many sexually transmitted infections (STIs) (Green, 1994). The World Health Organization (WHO) has advocated the inclusion of traditional healers in National AIDS programmes since the early 1990s (WHO, 1990). Unfortunately, this has rarely happened.

African traditional medicine encompasses a diverse range of practices, including herbalism and spiritualism, and traditional healers represent a range of individuals who call themselves diviners, priests, faith healers or bone-setters, among others. The term 'traditional healer' used here, though an oversimplification of a complex range of practices, refers to either herbalists, spiritualists or to those (the great majority of healers) involved in both realms.

African traditional healers reflect the great variety of cultures and belief systems on the continent, and possess equally varied experience, training and educational backgrounds. This diversity is further enhanced by their adaptation to the dramatic social changes that have affected much of the region since colonization, such as urbanization, globalization, population migration and displacement, and civil conflicts (Good, 1987). Whenever African healers' knowledge, attitudes, beliefs and practices about STIs and AIDS have been explored, findings have reflected the stage of the epidemic, the amount of information these healers have been exposed to, and their pre-existing belief systems about health and disease in general, and STIs and AIDS in particular.

Many reports have noted the genuine interest and enthusiasm of traditional healers to collaborate with their biomedical counterparts. Social research has shown that, in many countries, healers could name and describe numerous types of STIs (which do not always correspond to the biomedical definition). However, few of them consider AIDS an 'African' disease (Green, 1992; Green, 1993). Many traditional beliefs about the prevention of STIs or AIDS include limiting the number of sexual partners, wearing protective charms or tattoos, having 'strong blood', using condoms to reduce the risk of 'pollution' or undergoing a 'traditional vaccination' consisting of introducing herbs into skin incisions (Green, 1992; Green, 1993; Nzima, 1996; Schoepf, 1992). In numerous cases, condoms have become acceptable to traditional healers. Although many African healers consider semen an important element for nourishing a growing foetus and maintaining the mother's health and beauty, their concern for family and cultural survival can override this belief and allow them to promote condom use (Green, 1993; Schoepf, 1992).



Traditional healer providing community education in Uganda

Lastly, it has been found that when there is a mutual willingness on the part of traditional healers and conventional health practitioners to collaborate, and when there is a genuine interest in the beliefs and values of traditional healers, as well as a respect for their practices, a bridge can be built between the two complementary health systems. This document is an attempt to describe and record the lessons learned in three such collaborative projects in East Africa, with the aim of sharing information for the benefit of communities who trust and believe in the practices of traditional healers.

The aim of this document is to describe three initiatives that have narrowed the gap between the traditional and biomedical health systems in different ways, and to highlight their far-reaching benefits with regard to HIV prevention, treatment access and care for people living with HIV/AIDS (PLWHA), their families, caregivers and communities. The projects described here were chosen as a result of an earlier study that looked broadly at initiatives in sub-Saharan Africa involving collaboration with traditional healers for AIDS prevention. The three collaborative initiatives described here are certainly not the only ones in East Africa, but they were selected because of their long-term existence (all of them started in the early 1990s) and experience in working with traditional healers. Each of these initiatives is a reaction to a different context or situation, thus it was created with different objectives in mind. The first two—in Kenya and the United Republic of Tanzania—have integrated a traditional medicine component into more comprehensive AIDS prevention and care programmes, while the Ugandan project dedicated itself entirely to building collaboration between traditional and biomedical healing systems for AIDS. This document focuses on how each of the projects built a collaborative relationship with traditional healers and how this relationship has helped surrounding communities. At the end of each chapter, each project has been summarized in a table and analysed with respect to UNAIDS Best Practice criteria. New criteria have also been proposed for the specific type of collaboration pioneered by each initiative.

This documentation will undoubtedly highlight the need for more research in the uses, effects, benefits and challenges of traditional medicine. A multiplicity of variables need to be assessed and it is only with systematic documentation of the already existing best practices that we hope to answer crucial questions regarding the effectiveness, advantages and limitations of traditional medicine, and determine how we can further incorporate traditional medicine into the HIV/AIDS response.

We hope that documenting some of the best practices of the few organizations in East Africa that have initiated collaboration with traditional healers in fighting HIV/AIDS will stimulate positive thinking, promote practical action and provide an opportunity for sharing experiences in responding to the challenges of AIDS care and prevention in Africa.

III. WOMEN, AIDS AND TRADITIONAL MEDICINE IN KENYA

Background statistics*: Kenya	
Total population in millions (1999)	29.5
Urban population (1997)	30%
Annual population growth rate (1990–1998)	2.6%
Infant mortality rate (1999)	65 per 1000 live births
Life expectancy (1998)	52
Total fertility rate (1998)	4.4
Literacy rate (1995)	Male: 86% Female: 70%
Per capita GNP (1997)	US\$340
HIV prevalence—general population (1999)	13.1%
* Source: <i>AIDS in Africa, Country by Country Report, UNAIDS 2000</i> <i>Kenya National HIV/AIDS Strategic Plan, 2000–2005</i>	

AIDS in Kenya

In Kenya, AIDS is a tragedy of devastating proportions. Seven hundred people die every day from the disease and, since the epidemic started, more than 1.5 million Kenyans have died of AIDS. Most AIDS deaths occur between the ages of 25 and 35 in men and 20 and 30 in women. Thus, most infections occur in the teenage years and early 20s. The country is faced with more than 2 million HIV-positive individuals and half of the beds in government hospitals are occupied by PLWHA. National HIV prevalence rose from 5.3% in 1990 to 13.1% in 1999 and shows signs of stabilizing at around 14%. Seroprevalence among pregnant women ranges from 6–17% in low-prevalence areas to 25–30% in higher-prevalence areas (Kenya National HIV/AIDS Strategic Plan, 2000).

Following the November 1999 Presidential address declaring AIDS a national disaster, a National AIDS Control Council (NACC) was created by presidential decree with the objective of coordinating the efforts of the government, NGOs, CBOs, development partners, religious groups and PLWHA. A national network of 450 NGOs, CBOs and religious groups, formed in 1990, called Kenya AIDS NGO Consortium (KANCO), has as its mission providing and promoting leadership, solidarity and collaboration among members for collective action towards an effective response to HIV/AIDS. In addition, the Kenya HIV/AIDS Consultative Group, a forum including heads of UN agencies, bilateral donors, the Government of Kenya, PLWHA, representatives of private sectors, NGOs and religious organizations, was formed to set priorities, and advocate and promote multi-sectoral approaches, as well as actions recommended by a technical working group.

Recent studies have demonstrated that the health system is being overstretched by the number of AIDS patients and that there is a large funding need to scale up care and prevention programmes (UNAIDS, 2000). AIDS has also highlighted many weaknesses in the social system and other ethical, legal and economic issues with which society was previously little concerned. The epidemic has placed unprecedented demands on the limited social services and it is estimated that the 1 million children orphaned by AIDS in Kenya have already overwhelmed existing systems of adoption.

In Kenya today, fear, ignorance and lack of open dialogue about HIV/AIDS have placed tremendous pressure on family bonds. Gender biases are exacerbated as infected women bear more rejection than their male counterparts. Women are also disproportionately responsible for the care of those infected with HIV/AIDS, often without sufficient information, medication or support.

Since the beginning of the epidemic, governmental and nongovernmental organizations, CBOs, and religious groups have been actively involved in fighting the epidemic. However, few have initiated a relationship with traditional healers as has WOFAK—Women Fighting AIDS in Kenya.

Women Fighting AIDS in Kenya (WOFAK): objectives and activities

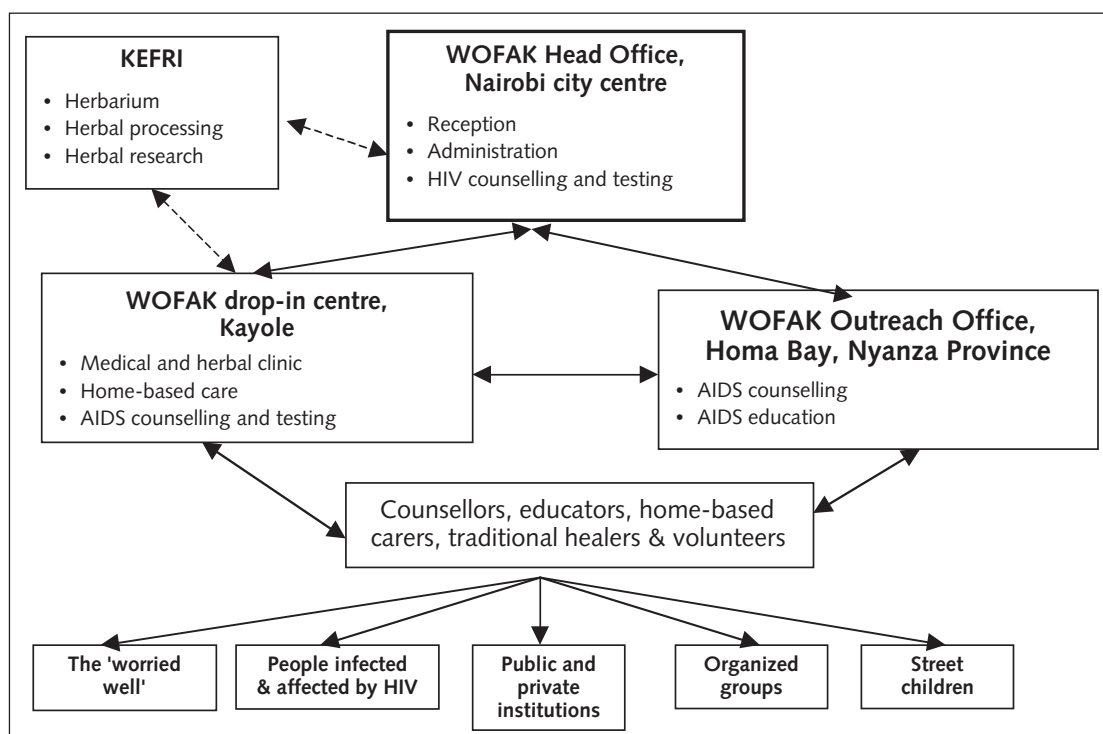
In 1993, with the realization that women were particularly hard hit by the discrimination, stigmatization and rejection that goes along with HIV infection, 10 infected and affected women got together and initiated WOFAK as an AIDS support organization. WOFAK was registered as an NGO to support and empower affected and infected women to live positively with HIV/AIDS, and to help them access the limited services available. With a board of directors and a constitution, WOFAK began operations from an office in Nairobi in January 1994. Since then, membership has grown to more than 450 women infected and affected by HIV/AIDS. The main support WOFAK provides is bringing women living with HIV/AIDS together to share experiences and provide mutual support. The activities undertaken by WOFAK include:

- counselling and psychosocial support for infected and affected children and adults;
- traditional medicine for the relief of opportunistic infections;
- HIV/AIDS education and awareness to different groups, including youth throughout Kenya;
- reproductive health services;
- home-based care;
- advocacy for the rights of women with HIV/AIDS;
- training in counselling, education and home-based care for WOFAK members and traditional healers;
- training in income-generating projects.

WOFAK is comprised of 20 permanent staff and five volunteers, including counsellors, educators, home-based carers and a traditional healer. Below is an organogram showing WOFAK's structure and the collaboration between WOFAK and Kenya Forestry Research Institute (KEFRI).



Most of WOFAK's services are offered in the WOFAK drop-in centre, Kayole, located in the Eastlands of Nairobi, about 30km from the city centre.



Dorothy Onyango—WOFAK Founder and Programme Director



Dorothy, a single mother with three children, was diagnosed as HIV-positive in 1990. She describes this period as a very trying time, as she was taking care of her mother who also had the deadly virus. When she felt the courage to share her HIV status with a friend of hers whose husband died of HIV, this friend helped her attend a women's meeting in the Netherlands. There, she met HIV-positive women from all over the world and was inspired to start a support group for women living with AIDS in Kenya. This was the humble beginning of WOFAC. Initially, these women were just assisting each other but, with time, more and more women became interested. Dorothy is very proud of what WOFAC has achieved since then in care, counselling, advocacy, orphan support and especially in empowering HIV-positive women. Dorothy looks forward to the bimonthly WOFAC group therapy sessions, where women mix and learn from each other. She is, however, overwhelmed with the many responsibilities involved with running an organization.

Dorothy feels that traditional medicine is a very valuable option for WOFAC clients, as Western medicine is much too expensive for WOFAC's target population. She explains that the government is generally opposed to the use of traditional medicine, so WOFAC only uses it with its own members until it is officially tested at the Kenya Medical Research Institute (KEMRI). *"Most people prefer herbal medicine as there are no side effects. It is our first aid and we have seen only positive impact on our clients."*

Nicanor: a WOFAK client

Though he is alone most of the time, Nicanor has a wife who works and three children aged 8, 5 and 3. He had been sick for over six months when he developed a very bad cough. Twice this year he was admitted to hospital with a wound on his arm and a rash all over his body. Nicanor was



Nicanor receiving herbal medicine from Fredrick Olum, WOFAK healer

formerly employed, but is now jobless as he is too sick to work. Luckily, one of the community leaders asked WOFAK to make a home visit to see Nicanor. As a result, two months ago, he started using traditional medicine when he was unable to walk.

He is relieved that, with treatment, he can now walk. Although he went to conventional biomedical clinics and the doctor prescribed treatment, Nicanor was unable to afford it on the meagre income his wife earns selling rice. So he is grateful for the treatment and care from WOFAK.

WOFAK and traditional medicine—a new initiative

In May 1999, with the inspiration of the first International Meeting on Traditional Medicine and AIDS, held in Dakar, Senegal, and with funds from the Ford Foundation, WOFAK embarked on an exciting new adventure to support the discussion and use of traditional therapies for HIV-associated opportunistic infections. WOFAK's mission with regard to herbal medicine is: *to sustain and promote various forms of traditional medicine and to develop ties with beneficial cultural practices throughout the country.*

To further its objectives, WOFAK has established a working agreement and collaboration with KEFRI to grow, process and conduct safety assessment and analyses of some medicinal herbs. So far, useful herbal therapies have been identified for herpes zoster, diarrhoea, malaria, skin rash, cough, fever and joint pains. The strong relationship between KEFRI and WOFAK is reinforced by one KEFRI herbalist, Fredrick Olum, who works at the WOFAK drop-in centre two days a week treating clients with herbal medicine.

WOFAK traditional medicine activities:

- *Identification of traditional medicines:* This includes the collection of raw materials by the KEFRI herbalist and processing through KEFRI. Traditional medicines are also identified in training seminars and workshops, as well as through group therapy sessions. WOFAK group therapy takes place twice a month and over 50 women come together to share experiences with experts in both herbal and biomedicine. Members bring samples of the plants they are using and are taught how to properly collect and store them. This is one empowering way for women to take control of their health in an accessible and affordable manner. WOFAK documents the names and uses of medicinal plants identified by members in these therapy and training sessions.
- *Collaboration between biomedical doctors and traditional healers:* In general, the collaboration between the two health systems is low in Kenya, as in many other countries of East Africa, but WOFAK considers it an important element of good-quality health services. The main activity undertaken in this area is that of encouraging cross-referral. Within the WOFAK drop-in centre, there are two clinic rooms side by side—one for traditional medicine and one for biomedicine.

The nurse or doctor refers to the herbalist and vice versa, depending on the condition, the medicine available, or the patient's preference. Screening through conventional testing is done to determine the problem before treatment begins. The clinic has one community nurse, one traditional healer, one part-time doctor and two herbal nurses.



Side by side, traditional and biomedical clinics at the WOFAK drop-in centre in Kayole, Nairobi.

Fredrick Olum: Traditional Healer, WOFAK and KEFRI

Fredrick, a herbalist working at KEFRI, inherited knowledge about medicinal plants from his maternal grandmother, who used to send him to collect herbs in the garden. Though she died long ago, he says her spirit is still teaching him through his dreams. He explains, *"At night, I will dream of a plant and be forced to use it the next day or she will come back in a dream and ask why I haven't used it."*

In 1990, the director of KEFRI, who was very interested in herbal medicine, set up the herbarium and other traditional medicine projects. Through KEFRI, more than 3800 species of medicinal plants from all over Kenya have been identified and processed. After this director left in 1995, the activities of the herbarium declined.



KEFRI herbarium

Fredrick has been treating people with herbal medicine since 1985 and began working with WOFAK in 1999. His collaboration with WOFAK began when Eunice Odongo, a lab technician at KEFRI, asked him if he could provide herbs for the WOFAK drop-in centre in Kayole two afternoons a week and collaborating with the biomedical clinic in the next room. He says, *"It is here that I know my herbs were working"*. He says he is gratified because people respond well to his herbal treatment, and many people are availing of both the herbal and biomedical approaches. His most successful treatments are for oral thrush, herpes zoster and cough. He has also learned about counselling and

home-based care through WOFAK. The collaboration between Fredrick and WOFAK is protected by an agreement that states that his herbal secrets will not be divulged without his approval. Thus, the trust is maintained between the two parties.

Fredrick feels he has benefited from WOFAK in that he has learned a great deal about HIV/AIDS prevention and care, which helps his work with patients at the WOFAK clinic and in their homes. He has three daughters and three sons, but only the youngest one, who is nine years old, is interested in learning about traditional medicine to carry on the family tradition.

- *Training of healers in HIV/AIDS counselling and education skills:* Two training sessions have taken place—one in 1999 and one in 2000. The first three-day training was held in Nyanza province for 34 participants, 20 of whom were traditional healers. The objective was to establish collaboration between people living with HIV/AIDS, conventional researchers and traditional healers. Issues highlighted included the AIDS situation in Kenya and in Nyanza Province, traditional healers' views on health and disease, the role of traditional healers in AIDS control,

ethnomedicine in Kenya, traditional medicine in the management of opportunistic infections, access to treatment for HIV/AIDS, home-based care and protection of intellectual property rights. The second training session covered similar topics but included counselling skills and the identification of herbs for some opportunistic infections.



- *AIDS education and education against harmful traditional practices* in schools, for religious groups, *matatu*¹ drivers, youth groups and other NGOs. Harmful traditional practices can include: widow inheritance, early marriage, female genital mutilation and circumcision.
- *Provision of technical assistance* to projects related to the value of traditional medicine.
- *Income-generation* and cost-sharing on use of traditional medicine. Income-generating activities include hair dressing, shopkeeping, and fruit-, vegetable- and paraffin-vending. WOFAK has drawn up a contract with two herbalists who supply herbal medicine for WOFAK patients. WOFAK members are treated free of charge, but non-members pay a small fee.
- *Development of a data bank* on Kenyan healers and their areas of expertise, which includes name and full contact address of the healer, a short biography (age, level of education, length of training, etc), area of operation, area of specialization and list of herbal remedies used (roots, leaves, herbs, how they are prepared, their dosage and what they treat).
- *Ensuring confidentiality and quality control* of the herbs being used through code names and agreements with healers.

Joseph Parmuat: a traditional healer, WOFAK



As a traditional healer operating in three clinics (one in Dagoretti, which is in the outskirts of Nairobi; one in Malaba, along the border with Uganda; and one in Loitokitok, Masai), Joseph is extremely busy. He is in his mid-thirties and has arranged his Dagoretti clinic so that it resembles a modern clinic with a waiting room adorned with public health posters, and a consulting room with his herbal medicines neatly organized on shelves. In his very matter-of-fact manner, he explains that, unfortunately, he is unable to expand his services further as his patients trust only him and would be wary of newcomers. He, therefore, cannot let anyone else operate his other clinics; only his wife helps in the clinic in Masai.

Having learned AIDS education and counselling skills from WOFAK, he has tried to gather patients together to educate them on these issues. He also advises on condom use, but is unable to distribute condoms for he has no reliable supply himself.

Though Joseph has worked closely with the University of Nairobi's Department of Pharmacy in testing his herbs in the lab, he feels that his greatest challenge is the collaboration with biomedical health workers as they are generally not willing to work with healers. He believes that about 98% of his patients come to him after Western medicine has failed them. He says that, in contrast to his biomedical counterparts, he is open to collaboration and does not hesitate to refer patients back to the hospital for conditions he cannot manage.

¹ Minibuses used for public transportation in many sub-Saharan African countries

Lessons learned from WOFAK

WOFAK works with very limited resources, in extremely marginalized communities and with high rates of HIV infection. Some factors in the success of WOFAK include:

- **The dedicated staff members** who walk for miles in the glaring sun to visit the homes of clients, who often have little or no family support and limited resources for food and medicine. WOFAK's home-care service may be the client's only source of food and/or care in a highly stigmatized environment.
- **The collaboration with institutions such as KEFRI** that enables WOFAK to provide its traditional medicine. KEFRI processes herbs and allows the herbalist to work for WOFAK two days a week. The traditional medicine component is a valuable addition to the care and support services of WOFAK as it leads to clients' empowerment and their ability to care for themselves.
- **The care and openness of WOFAK towards all clients who are HIV-infected and affected**, which is an important step in fighting stigma and working towards a more open Kenyan society.
- **The combination of traditional and biomedical care services provided at WOFAK's drop-in centre**, which is a unique and pioneering step and a highly positive development for WOFAK clients. This open relationship allows for true collaboration, under one roof, in a genuine area of need. Based on input from the herbalist and the nurse, clients are able to decide which medicines are best for them.

Eunice Odongo: Programme Officer, Care and Support, WOFAK

Though she was trained as a lab technician, Eunice calls herself a herbalist by experience with 'interest added'. In 1996, she tested positive for HIV after delivering a baby boy. She had painful herpes zoster on her face, which was successfully treated with herbal medicine. She was soon relieved of the pain and had no scarring.

She worked at KEFRI for 10 years before she went public with her HIV status in 1999. She then took a year off from KEFRI to dedicate her time fully to WOFAK. As one of the few WOFAK members open about her HIV status, Eunice is also the head of the herbal medicine project. Her enthusiasm and zeal make for passionate testimonies on the value of traditional medicine for people living with HIV.

Eunice works as a home-based care coordinator, trainer, counsellor, consultant and herbal nurse at WOFAK. She organizes the training of traditional healers and works with them in providing care and support for clients. In addition, as a true AIDS activist, Eunice networks with other AIDS NGOs in Nairobi and globally for the rights of women with HIV.



She believes in the need for meaningful representation of traditional healers in the planning, development and implementation of programmes and policies. Eunice stresses that, *"the accessibility and availability of traditional healers in rural populations and their unique continued popularity give them an important potential as collaborating partners in HIV/AIDS activities, especially regarding health, illness, and personal and social problems."*

Eunice is passionate about her work with traditional medicine and this has allowed her to participate in numerous conferences on the subject. At the last World AIDS Conference, held in Durban in 2000, participants and traditional healers came up with the following recommendations that Eunice felt were important to share:

- all countries should develop a legal framework for traditional medicine.
- all traditional healers should be empowered to take an active role as IEC agents.
- this process should be integrated in such a way that:
 - a) healers collaborate with modern medical infrastructures
 - b) local structures are created to facilitate people's access to health-care services
 - c) healers participate in biomedical research
- an international office should be created for the protection of traditional medical knowledge
- an international council of professional, traditional medical organizations should be created to coordinate and provide advice regarding healer activities
- the sources of traditional medical knowledge should be identified and promoted.

SUMMARY ANALYSIS OF WOFAK

LESSONS LEARNED	MAIN COLLABORATORS	CHALLENGES	FUTURE PLANS
<ul style="list-style-type: none"> Traditional healers are very valuable, not only as collaborators, but also as instigators of more innovative and effective campaigns for HIV/AIDS prevention, care and support Traditional healers form long-term innovative and participatory support groups, which have proven successful in prevention, care and support to HIV-infected and -affected people Many traditional healers have migrated from rural areas to make herbal medicines more available and accessible to urban dwellers Communication with traditional healers calls for face-to-face contact, especially in the case of ceremonies and during the use of herbal medicines Traditional healers are capable of providing culture-specific information on attitudes, beliefs and practices in relation to sexuality Traditional healers are catalysts Traditional healers can provide home-based care in relation to sexual behaviour and HIV/AIDS Traditional healers can provide basic counselling for patients and families 	<ul style="list-style-type: none"> AMREF Kenya AIDS Society (KAS) Kenya AIDS NGO Consortium (KANCO) Kenya Forestry Research Institute (KEFRI) Kenya Medical Research Institute (KEMRI) MoH National AIDS Control Council (NACC) Society for Women, AIDS in Kenya (SWAK) 	<ul style="list-style-type: none"> AIDS-related information materials are all in English, thus they are not relevant to much of WOFAK's target audience The best herbal medicine comes from Mombasa, which is very far away and WOFAK does not have the resources to collect it Many traditional healers still lack counselling and home-based-care skills to cope with the immensity of the AIDS problem WOFAK would like to cover the whole country, but lacks the resources Many traditional healers lack skills in the packaging and processing of herbs Traditional healers are not recognized in society, hence there is a loss of indigenous knowledge WOFAK's budgetary control is not clearly defined WOFAK is dependent on a very few traditional healers for the traditional medicine component 	<ul style="list-style-type: none"> Increase production of medicinal plants through the development of traditional medicinal plant nurseries Develop a resource centre on traditional medicine and AIDS to organize information exchange through seminars, workshops, publications, networking and appropriate information, educational and communication materials

BEST PRACTICE CRITERIA ANALYSIS OF WOFAK

Relevance	Effectiveness	Ethical soundness	Efficiency	Sustainability
<ul style="list-style-type: none"> Objectives clearly stated Eight years of experience Only service of its kind in poor, peri-urban area, which has high HIV prevalence in marginalized communities PLWHA (especially women) highly stigmatized and rejected in Kenya 	<ul style="list-style-type: none"> No reported failures with traditional medicine so far Traditional healers act as gatekeepers within target communities, identifying people needing support and recommending WOFAK services, such as home visits, which include treatment and food Traditional healers distribute condoms and refer clients for HIV testing Traditional healers keep records on client treatments and follow-up Healers distribute educational materials through <i>chief's barazas</i> (village meetings) or as community leaders Healers transmit counselling and home-based care skills to other traditional healers Traditional healers initiated an organization after a WOFAK seminar, which includes a collaborative clinic with herbal and modern medicine 	<ul style="list-style-type: none"> Patient confidentiality emphasized Agreement signed between WOFAK and healers supplying herbs One WOFAK traditional healer works within KEFRI Herbal medicines have been tested at KEFRI Strong collaboration with KEFRI and NACC 	<ul style="list-style-type: none"> According to WOFAK external assessment² the few available resources are well utilized; herbal medicine is cheap; WOFAK pays traditional healers for herbal medicine, thus creating an income-generating activity for them; WOFAK's reporting system is good, and accounts are audited annually. 	<ul style="list-style-type: none"> Relies on donor support Clinic run on cost-sharing basis Members pay monthly registration fee Receives donations from 'WOFAK friends' (individual donors) Committed staff, board and volunteers Extensive network both nationally and internationally Strong support from collaborating agencies (NACC, KEFRI and KANCO) and community Staff members get on-the-job herbal training Since the beginning, WOFAK has been able to implement a lot with extremely limited resources

WOFAK's SPECIFIC CRITERIA/APPROACH FOR TRADITIONAL MEDICINE/BIOMEDICINE COLLABORATION

Criteria for selecting traditional healers	Approach used to build trust with healers	Approach used to involve BHPs
<ul style="list-style-type: none"> Through KEFRI's data base on traditional healers Through healers who already know WOFAK Through the Traditional Healers Association under the Ministry of Culture and Social Services Through sharing experiences of successful treatments with women during group therapy at WOFAK Through community leaders 	<ul style="list-style-type: none"> Healers gained trust when they knew that WOFAK was not an organization of researchers WOFAK brought healers together and, through sharing their ideas, the healers agreed to work together. Their initial fear was that researchers would take their samples and not give them proper credit. WOFAK explained that the aim was to treat PLWHA and not to take their samples 	<ul style="list-style-type: none"> Health workers work side by side with herbalist in WOFAK's drop-in centre Joint seminars and workshops for traditional healers and biomedical health practitioners. Discussions and information sharing for the herbalists and conventional medics Sensitization to reduce human suffering by treating diseases using different approaches

² Assessment conducted by the organization 'Improve Your Business, Kenya' in 1999.

IV. AIDS CARE AND PREVENTION: AN INTEGRATED MODEL IN THE UNITED REPUBLIC OF TANZANIA

Background statistics: United Republic of Tanzania*	
Total population in millions (1999)	32.8
Urban population (2000)	35%
Annual population growth rate (1990–1998)	2.9%
Infant mortality (1998)	80 per 1000 live births
Life expectancy (1998)	48
Total fertility rate (1998)	5.4
Literacy rate (1995)	Male: 79% Female: 57%
Per capita GNP (1997)	US\$210
Adult HIV prevalence (1999)	8%
<i>*Source: AIDS in Africa, Country by Country, UNAIDS 2000</i>	

AIDS in the United Republic of Tanzania

In the early 1990s, annual deaths from AIDS were estimated at 20–30 000 or 5–7% of all deaths in Tanzania. However, a study by the Ministry of Health in 1997 re-estimated the burden of AIDS mortality and found that AIDS accounts for more deaths than the next four leading causes combined. AIDS is also responsible for four-to-seven times more deaths in women than men, especially in urban areas. In rural areas, the virus accounts for one-third to one-half of deaths among men in their early thirties. A World Bank Country Study in 1997 estimated that, by the year 2010, the number of HIV-infected people in Tanzania will reach 6–17% of the population (DANIDA, 1999).

About 90% of reported AIDS cases occur in the 15–49-year-old age group. Women in Tanzania, as in most sub-Saharan countries, are more at risk of contracting HIV than are men and have a seropositive peak between the ages of 20 and 24, compared to 25–35 for men.

In addition to the National AIDS Control Programme (NACP) of the Ministry of Health, Tanzania has both a National Advisory Board on AIDS (NABA) and a Tanzania AIDS Commission. NABA was established by the Prime Minister and is headed by His Excellency former President Ali Hassan Mwinyi. The Commission, currently being established, is headed by Major General Lupoga and is to be the leading body responsible for coordinating the multisectoral response to HIV and AIDS.

Tanga AIDS Working Group (TAWG): objectives and activities

From 1992 to 1998, there were 4792 cases of AIDS reported in the Tanga Region, yet the NACP estimates that only one-in-five cases were reported. These figures invariably suggest high infection rates in the region, hence the Tanga AIDS Working Group's (TAWG's) activities are critical in areas where little, if anything, is offered for HIV prevention and care services.

Background and history of TAWG

In the words of one of TAWG's founders, *TAWG sprouted from a traditional healer's initiative in 1990, in collaboration with health workers from the government hospital in Pangani—a coastal*

town just 60km from Tanga. During a workshop, Waziri Mrisho, an 84-year-old healer, offered to treat a hospitalized AIDS patient with his plant medicines. Although Mrisho explained that his medicines had successfully been used for centuries to treat the symptoms this patient displayed, the hospital staff didn't expect to see the patient gain weight and improve after taking Waziri's medicines. The patient surprisingly improved, was discharged from the hospital, and is reportedly still alive today. From that exciting beginning sprung TAWG (Scheinman, 2000).

In Tanzania, as in many other countries in sub-Saharan Africa, it is well known that the burden of primary health care is on traditional medicine, especially since the establishment of cost-sharing in the hospitals. There is a Department of Traditional Medicine in the Ministry of Health and traditional healers are organized at all levels of the district health team. The Institute of Traditional Medicine in Dar es Salaam has established guidelines for collaboration between traditional healers and biomedical practitioners and is now working on a legal framework. In addition, a research network is being established between the National Institute of Medical Research and traditional healer organizations.

The activities of TAWG cover three district towns in the Tanga Region, with a head office situated in Bombo Hospital in Tanga town, which is the government referral hospital for 1.5 million people in the region. In late 2000, TAWG was treating approximately 400 patients with the overall goals of bridging the gap between traditional and hospital medicine for the benefit of people living with AIDS and reducing HIV transmission in the region.

TAWG was built on a foundation of early collaboration between healers who had treatment for some AIDS-associated conditions and doctors who were truly interested in partnering for the benefit of their patients. In association with local healers, three efficacious herbal remedies were developed for the treatment of a variety of ailments commonly associated with HIV/AIDS. Thereafter, a home-care service was initiated for HIV/AIDS patients and their families. Today, home visits involving the monitoring of general health, the administering of traditional remedies and the provision of counselling services are the backbone of the group's daily work.

Through collaborating physicians, TAWG acquired space within the compound of the Regional Hospital, and now occupies a floor in an old German building, called Cliff Block, overlooking scenic Tanga Bay. In 1994, the organization became an officially registered NGO and is now a major player in the fight against HIV/AIDS in the Tanga Region. The Regional AIDS Control Coordinator (RACC) has always been on TAWG's Board of Directors, and TAWG works closely with the regional and district health teams.



**The United Republic of Tanzania with
TAWG's operational area
(Muheza, Pangani and Tanga)**

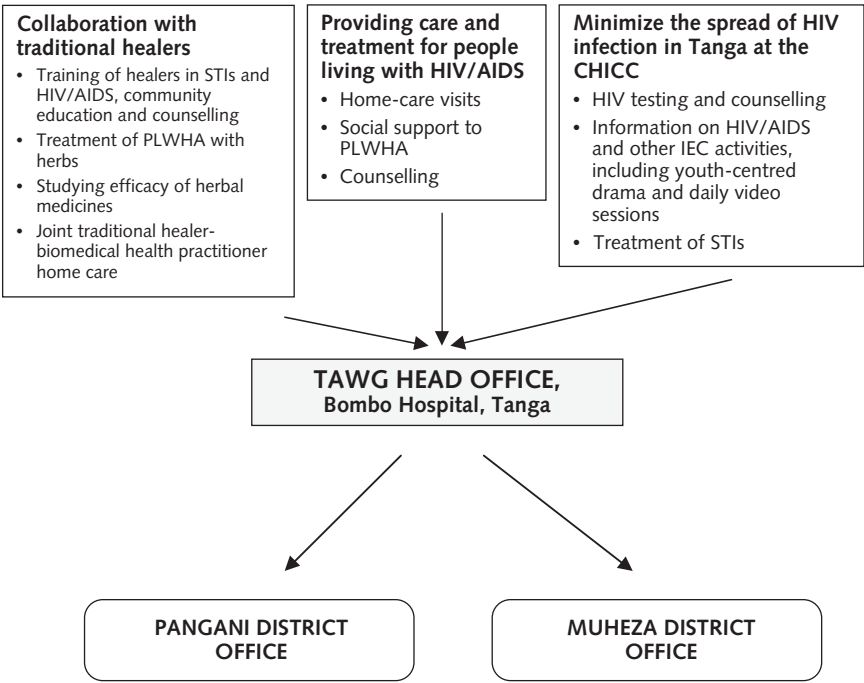
In order to get critical AIDS and STI information out to the people, TAWG initiated a Community Health Information and Care Centre (CHICC) located in the central business area of Tanga town. The CHICC is staffed by nurses who are trained as counsellors and community educators.

In Tanzania, the work of TAWG is an outstanding example of how positive results can be achieved in the fight against AIDS by using local, culturally relevant expertise and resources to provide low-cost care and prevention for people living with AIDS.

Objectives of TAWG

1. To provide treatment for people living with HIV/AIDS
2. To minimize the spread of HIV infection in Tanga
3. To collaborate with traditional healers

Summary chart of TAWG organization and activities



Dr Mberesero, TAWG co-founder



A medical doctor by training, Dr Mberesero is married with three children and works at Bombo, the Tanga Regional Hospital. Dr Mberesero is a founding member of TAWG and is currently the Vice-Chairperson of the Board of Trustees. She explains that TAWG was started by a German doctor, Dr Elmar Ulrich, who was working in nearby Pangani Hospital at the time. He observed that patients delayed reporting to the hospital for treatment and was curious about the reasons behind the delays. He discovered that patients first visited traditional healers, which prompted him to approach the healers.

Dr Mberesero’s personal interest in joining forces with traditional healers also stemmed from the fact that her grandfather was a healer. Currently, she volunteers with TAWG, and is involved in designing and facilitating healer training. She is also part of TAWG’s home-care team.

Dr Mberesero stresses that, through TAWG activities, healers have been trained as HIV/AIDS counsellors, peer educators, condom distributors and better health-care providers. They have a better understanding of HIV/AIDS, can sensitize communities and refer patients with complications that they cannot manage.

One of the challenges TAWG faces is the reluctance of some healers to collaborate because they fear that their treatment secrets will be stolen. Dr Mberesero explains the situation to traditional healers in the following way: “We are not interested in becoming famous; we give them the recognition they deserve and feedback on the research we conduct. But we also clarify that many people use the same herbs, so who really owns them? Aren’t they community property?” She also noted the resistance of her medical colleagues who ask her, “Why do you collaborate with someone who has never gone to school?” Dr Mberesero views traditional medicine as valuable because it differs from biomedicine, unlike some people who would like to convert healers into community health workers. She says, “We should keep traditional medicine as traditional medicine and not try to make it more like Western medicine”. Some hospital workers are now referring patients to TAWG for traditional medicine and the Regional Medical Officer is open to collaboration.

What does TAWG do?

TAWG's response to the HIV/AIDS crisis in Tanga acknowledges the need for increased awareness and prevention activities in a context where stigma and denial are still high. It also recognizes the need for treatment and care for the increasing numbers of people infected with HIV.



HIV testing and counselling services in a supportive environment

A comprehensive response to AIDS includes HIV testing and counselling. Testing services are provided at the TAWG head office and at the CHICC, while counselling is also offered at home. Today, many hospital personnel know that TAWG staff members have been trained as counsellors, so patients are referred to either of the TAWG offices for testing and counselling. The story of one TAWG client illustrates the experience of many TAWG patients: *"Matilda went alone to be tested. She had mentally prepared for the results of her test, which she assumed would be positive. She was warmly welcomed by Mama Ussi, a TAWG nurse, and was counselled by both her and Dr Chaze, and then tested. A couple of days later, she got*

a confirmation of her positive test results and was enrolled as a client" (McMillen, 2000). If a client tests positive, he/she can enrol as a TAWG member and benefit from free treatment, home visits and counselling. Through testing and counselling, HIV/AIDS patients have been encouraged to accept their condition and take the necessary steps to cope with it. With counselling, clients are better able to benefit from the traditional and modern treatment that TAWG provides. Numerous TAWG clients have testified as to their improved health status after testing, counselling and traditional treatment.

Home-care visits provided for people living with HIV/AIDS—a continuum of care

"TAWG's signature activity is treating patients in the hospital or at home with medicinal plants. Our plants work," says David Scheinman, one of TAWG's founding members, adding, *"they are low-cost, effective, readily available, provided to patients at no charge, and have been used by Tanzanian healers for centuries"* (Scheinman, 2000).

When clients are enrolled in the TAWG programme, they can use traditional medicines collected by a healer and distributed by the hospital. TAWG prescribes medicines at the doses given by healers, while physicians and nurses monitor the patients. If a patient responds well and has no adverse side effects, treatment continues. An often cited 'side effect' of traditional medicine treatment is increased appetite, which can be difficult if patients do not have enough food to eat.

TAWG has care providers in Tanga at the TAWG office and at the CHICC, situated in the Tanga city centre near the market. TAWG also has trained nurses and counsellors in Muheza and Pangani Districts. Patient home visits are carried out two days a week and are appreciated by clients because of the greater privacy and confidentiality available to them at home, compared to being in a hospital environment. Clients feel cared for during home visits and the nurse has a chance to discuss important issues with family members and other caregivers. One of the TAWG clients says of her nurse, *"The nurse gives me moyo and matumaini (heart and hope)"* (McMillen, 2000).

Currently, TAWG has approximately 800 confirmed HIV/AIDS registered patients. In 1999, in the three districts (Muheza, Pangani and Tanga), TAWG recorded the following activities:

Home-care contacts	1290
Inpatient contacts	249
Outpatient contacts	1432
Traditional medicine doses given	1079*

*Total number of monthly doses given by TAWG staff, excluding medicine given by traditional healers in their own offices.

According to the Regional AIDS Control Coordinator (RACC), the Tanga AIDS Working Group is treating almost 10% of all confirmed AIDS cases in the entire region of Tanga using traditional medicine.

Modern medicine is given to patients who visit the CHICC for STI services. TAWG tries to run the service on a cost-sharing basis. However, clients under the age of 20 are treated without charge to encourage them to seek care for STIs.

Mary: TAWG client

Mary first began to think that she might have HIV in 1995 when she was 27 years old and pregnant with her first child. She knew her husband was having an affair and she had heard rumours that his girlfriend's husband had died of AIDS. She warned him that he was risking their marriage and their lives, but he denied everything. At this time, he was drinking a lot and spending a lot of time out of the house. They weren't able to reconcile, so she decided to leave him and went to live with her sister.

After moving in with her sister, her health was stable and she carried her pregnancy to term without problems, but she was worried about her future in light of her husband's affair. To her relief, she gave birth to a healthy baby boy. But, at six months of age, his condition deteriorated. He died at one year of age (in 1996). Soon after the baby died, Mary received a message that her husband was also becoming very sick and weak. About the same time, Mary also started to get sick. She was coughing and was eventually admitted to the hospital in Moshi where she was diagnosed with TB. She completed the year-long TB treatment in August of 1998. Mary says that even though she spent a lot of money on hospital medicines she never regained her former level of health. She even turned to traditional healers but their medicines did not help her either; they just wasted a lot of her money, she says. Her condition continued to deteriorate.

Mary left Moshi and moved to Dar es Salaam to stay with her aunt. Mary was not able to take care of herself, and relied on her aunt for everything—food, bathing, clean clothes, etc. However, this aunt was older and not really able to give Mary the care she required. Mary's condition continued to worsen. About this time, Mary's other sister, Susana, encouraged her to come and stay with her and her family in Tanga. Susana was working as a housekeeper at Bombo Hospital and had heard of TAWG. She thought TAWG might be able to help Mary.

It was January of 1999 when Susana picked Mary up at the bus station in Tanga. She hardly recognized her because Mary looked so thin and sick. She could not even walk. Mary remembers that she had skin rashes, oral thrush, diarrhoea, high fever, cough and body aches. Mary told Susana that she had given up all hope ("*nimeshakata tamaa*"). Not only was her physical condition bad, she was also very depressed, confused and worried. The next day, Susana arranged for TAWG to come and visit Mary at home.

A nurse and doctor came and talked to Mary and, together, they decided that she should be tested for HIV. The nurse asked Mary if she knew what she had been tested for. Mary explained to her that she had been sick for a long time. The nurse then explained that she was HIV-positive, but that there was hope. She told her about TAWG and the traditional medicines people use that help them live longer.

The nurse made arrangements for Susana to come to the TAWG office to collect the herbal medicines. For the following few months, Mary still had no strength and was attended to by the home-care team. They monitored her condition, brought her medicines and, sometimes, milk and soap. They also helped Susana understand more about AIDS and how to care for Mary. After three months of using the medicines, Mary was able to go to TAWG's office for check-ups on her own. Her appetite returned, she regained strength and was able to return to daily activities such as cooking, cleaning and even fetching water. She felt free to go out and talk to her friends.

Mary believes it is the herbal medicines from TAWG that returned her to health because none of the medicines she previously used (from the hospital or other traditional healers) helped her. She continues to use the TAWG herbal medicines to maintain her condition, but because their preparation requires a lot of work, she does not use them daily unless she is bothered by a specific problem.

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Once, she stopped for two months and her condition worsened. Mary says that the herbal medicines are best at treating fungus, stomach problems and cough, especially when hospital medicines do not work. In addition, her periods, which had stopped, resumed on a regular basis. Now she says she is able to walk long distances, carry water, cook *ugali* for four people, clean the house and wash clothes. She feels more like herself and like a normal person. Although some of her skin problems still come and go, her other problems (lack of appetite and weight loss, thrush and body aches) are gone. Mary says she is much more optimistic about her future now than when she first arrived in Tanga.

Mary has also joined the support group for HIV-positive people at the CHICC. She says her fellow members help keep her spirits up. It makes her feel better to be with people who understand and can relate to her problems.

HIV/AIDS education through seminars, drama and the Community Health Information and Care Centre (CHICC)



TAWG works in association with 20 theatre groups to conduct performances aimed at increasing HIV awareness and behavioural change in the three target districts. Theatre group members have been trained in one-week seminars on HIV/AIDS issues and evaluation results indicate that performances stimulate conversation about AIDS and reach large numbers of people (McMillen, 2000). Besides offering STI services, the CHICC has books and pamphlets on AIDS, shows educational videos to the public six days a week, and regularly conducts educational seminars for specific groups such as health-care workers, teachers, students, workers in high-risk areas and traditional healers.

Mrs (Mama) Zimbabwe: a nurse with TAWG



"Traditional healers are good cooperators," says Mrs Zimbabwe, who is married with four children, and is a trained nurse and the coordinator of the CHICC of the Tanga AIDS Working Group. She joined TAWG in 1989 to work with people living with HIV/AIDS and to help them cope with life. *"I did not find any difficulty in working with traditional healers, since my previous work involved working with traditional birth attendants (TBAs),"* she says of her current job. She explained that health workers were motivated to collaborate with traditional healers as they realized that they were losing children to malaria, pneumonia and bilharzia. They felt that they could reach many more people through the network of traditional healers. *"In our first seminars with traditional healers, we simply listened to them describe to us which diseases they treated, what medicines they used and some came out and said that they treated HIV."*

Mama Zimbabwe is currently one of the counsellors with TAWG, based at the CHICC. She has done a great job, and her clients like her because of her motherly approach and the love she shows them. *"Counselling is a great thing for patients and I enjoy it. You get to understand the difficulties of people living with HIV/AIDS and those affected."* She has been involved in training more than 300 traditional healers in STIs and HIV/AIDS counselling, prevention and care—a role she believes in.

She describes her experience of working with traditional healers as a good one. *"Working with traditional birth attendants made us realize that traditional healers had much to offer to their patients, something that we hadn't paid much attention to. We later found out that healers were giving herbs to their patients for illnesses like convulsions, anaemia, pneumonia, bilharzia, and STIs, and patients were improving."* With more than 10 years of experience in the field, she is a strong asset to TAWG, especially given her love for new ideas and innovative ways of implementing them.

Social support for PLWHA

In an environment such as Tanga, where AIDS is still a highly stigmatized disease, the creation of a support group for clients was a critical link to improved AIDS care services.

One of TAWG's clients, Veronica, who joined the support group for HIV-positive people, says of her fellow members, *"Before joining the group, I was seriously sick and was only thinking of dying. I was encouraged by group members, who gave me additional ideas for treatment. Now, I feel stronger and can even give community AIDS education."*

TAWG was very instrumental in forming the Tanga Branch of SHDEPHA³, an association of people living with HIV/AIDS, founded in 1997. Association members meet at the CHICC every Tuesday and Friday morning, to share experiences, comfort each other and discuss how to live positively. Recently, they have started producing crafts to generate income.

Through its home-care programme, TAWG also provides material support (consisting of milk, eggs and soap) to the most needy patients.

Collaboration with traditional healers

TAWG believes that if healers are equipped with knowledge on how to identify HIV/AIDS, how it is contracted, spread, and can be prevented, they can advise their patients and other community members. This strategy has enabled TAWG to extend its services to people who do not come to the TAWG offices.

To ensure continuous dialogue and information exchange with as many traditional healers as possible, TAWG holds monthly meetings with healers and three-to-five-day seminars every quarter. TAWG educates traditional healers on HIV/AIDS, condom use, community education and aspects of primary health care, while healers share their perspectives and experiences with regard to their relationship with clients and their traditional medicines. One of the TAWG nurses describes the outcome of training, saying that traditional healers:

- have increased knowledge of HIV/AIDS (evaluation results indicate that healers involved in seminars know the modes of HIV transmission and prevention)
- make increased referral to health centres, counsellors and other traditional healers
- collaborate increasingly with biomedical health practitioners
- distribute condoms (which they get free from TAWG)
- take increased precautions against HIV infection during their work
- provide health education and HIV/AIDS counselling (at least half of the healers report that they educate family and community members on AIDS)
- keep records and reports of their patients
- actively participate in monthly meetings with TAWG
- help identify other healers who have medicine for treating HIV/AIDS.



TAWG works very closely with one healer, Mohamed Kasomo, in treating HIV/AIDS patients. Kasomo supplies herbal medicines to TAWG for a variety of AIDS-related conditions, including weight loss, diarrhoea, fungal infections (including oral thrush), and skin conditions (including herpes zoster). TAWG health-care workers distribute these medicines to patients from the head office in the Bombo Hospital and then monitor their progress. A study, conducted for TAWG in 2000, and anecdotal evidence from patients and health-care workers, indicates that many patients have experienced significant improvement in their quality of life, as well as a longer life than could have been expected in the absence of these herbal medicines. Whereas more research is needed to confirm or disprove these claims, herbs are one of the very few options for alleviating symptoms of HIV-associated opportunistic infections that could prove serious if left untreated.

Traditional medicine being prepared at Kasomo's home

³ *SHDEPHA+ stands for Service Health and Development for People with HIV/AIDS

Ethnobotanical research

TAWG's ethnobotanical research is simple and can be conducted with limited resources. The process is explained by one of TAWG's board members:

1. *After consulting with biomedical doctors, we identify a disease or condition we want to treat.*
2. *We discuss the disease with healers and get their opinions. Do they recognize or treat the disease?*
3. *We show healers pictures of the disease. Skin diseases are the easiest to treat.*
4. *We identify efficacious plant remedies already used by healers to treat targeted diseases.*
5. *If necessary, we carry out ethnobotanical research to find new plants from new sources.*
6. *We fill in botanical collection forms.*
7. *We collect the appropriate plants with healers.*
8. *We pay healers for their time.*
9. *We press leaf samples in a press and deliver them to a botanist.*
10. *The botanist identifies the family, genus and species.*
11. *We make sure the plant is not endangered.*
12. *We conduct a literature review, we check how other cultures use the plant and look for toxicity.*
13. *We get dosages from healers.*
14. *We recruit patients for observational study with healers.*
15. *We have a student with research skills carry out the study with the healer. This builds research capacity.*
16. *We monitor results and draw conclusions.*

The key to success is identifying knowledgeable healers and cultivating relationships with them. We accomplish this by giving healers professional respect, trust, access to the hospital, and a fair price for their time and plants (Scheinman, 2000).

Mohammed Kasomo: Traditional Healer, TAWG

Mohammed Kasomo (commonly known as *Bongo Mzizi*, a Swahili phrase for 'root genius') currently is TAWG's sole supplier of herbal medicines. He started as a herbalist in 1971, after being trained by his uncle who gave him the name *Bongo Mzizi*, seeing that he readily understood the complexity of herbal medicine. After his uncle died in 1973, his eldest son, Bongo's cousin, took over the responsibility of training him.



Bongo lives and works in the outskirts of Tanga, only a 15-minute bicycle ride from the TAWG office, in a two-room building, where, he explains, one room is for counselling and the other serves as a pharmacy. He started collaborating with TAWG in 1993, after he was trained as a HIV/AIDS counsellor and community educator. He claims he did not hesitate joining forces with TAWG, as he was aware that he was going to work with doctors and nurses—people with a common cause. At his office/clinic, he has two young men to help crush and pound the herbs while he follows up with his patients.

Through clinical observation by TAWG, Bongo's medicines have proven quite effective in treating common HIV/AIDS opportunistic infections, such as chronic diarrhoea, herpes zoster, oral thrush and wasting. His herbs are identified by numbers, and are given to patients in finely or coarsely ground form to be prepared at home as a tea to drink or as a topical application.

When clients come for consultation, Bongo says, "*I welcome them and ask questions about their health and life in general. After understanding the problem, I advise them to go to the hospital for further investigations like a blood test for malaria or HIV. If I see signs of HIV, I tell them that it might be 'this disease of nowadays'. Counselling helps and, if it is a new patient, I escort them to Cliff block (where the TAWG offices are located). If there are signs of witchcraft, I collaborate with other traditional healers and refer to them. I also talk to other family members.*"

—>

Through training, Bongo has gained skills in HIV counselling. *"Before training, I was counselling my patients on how to use herbs only. Now I tell them about the dangers of HIV/AIDS and how to avoid it,"* he says. Training and working with TAWG have changed local communities' perceptions of him. He has become quite popular as a herbalist and people come all the way from Dar es Salaam and Moshi, each about 350km from Tanga, to consult him. Local people also come to his office for advice on other health issues besides HIV/AIDS. *"People think I can heal any disease,"* he says. Community members generally come in the afternoons in groups of 8–10, and he uses the opportunity to educate them about HIV/AIDS. In addition, he advertises the AIDS video shows at the CHICC.

Bongo also gives education to his fellow healers on research as he is the Research Coordinator of CHAWATIATA, a local healers' association. Bongo highly values referral, especially for patients suffering from malaria, convulsions and anaemia. He uses forms designed by TAWG to monitor the effectiveness of his herbs.

Being the sole supplier of herbs to TAWG has also created problems as other healers are jealous of him—a situation TAWG is trying to address by involving more healers. He also explains that some patients are reluctant to take condoms, saying that they do not enjoy sex with a condom. Bongo replies, *"What is better: to enjoy sex or get a disease with no cure?"*

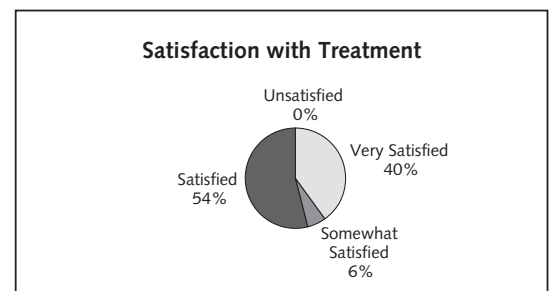
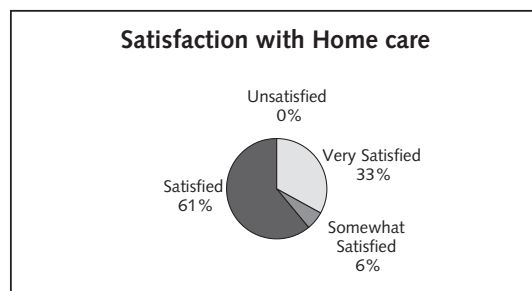
Client responses

In a recent evaluation of TAWG activities, patients reported that TAWG's most valuable service was that of providing traditional medicines, giving this as the main reason for registering with TAWG. Patients use traditional medicine to both treat and prevent medical problems. Interestingly, seven per cent of the respondents said they used the medicine only when they had problems. Most use the medicines to keep problems from arising or recurring (Sheinman, McMillen, 2000).

TAWG patients enthusiastically claim that the medicines work. After nearly 10 years of administering them, TAWG staff members believe they are right. Though TAWG has not used the biomedical gold standard of placebo-controlled clinical trials or biochemical studies, there is a compelling body of anecdotal and observational data from clients and staff indicating that these herbs do help.

Both clients and staff have noted that herbal medicines help to increase appetite and weight gain, stop diarrhoea, reduce fever, eliminate oral thrush, resolve skin rashes and fungus, cure herpes zoster and clear ulcers. Most patients reported seeing results within 7–30 days of beginning treatment and said they felt better, their appetite and strength increased, and they gained weight. Other frequently cited improvements include: cough decreased, headache stopped, urination and bowel movement increased, sleep improved and worries eased.

In TAWG's recent evaluation, clients reported the following:



TAWG Chairperson, Dr Mberesero, claims that traditional medicines work best at treating skin conditions, diarrhoea, appetite problems, fungal infections and oral thrush. Almost everyone agrees that herbal medicines are not very helpful for someone with advanced HIV/AIDS.

Thirty-two per cent of the clients reported that their symptoms returned after stopping the medicines. In addition, many clients noted that traditional treatment was the only medicine that gave them results. Most patients had already been treated with conventional biomedicines, with limited results. Many patients expected to improve with Western medicines, but did not, and have thus continued taking herbal medicines because they brought relief and few side effects (McMillen, 2000; Scheinman, 2000).



Maama Maharage: Traditional Healer, TAWG

Maama Maharage owns a small 'clinic' on the outskirts of Tanga. It is filled with gourds, some hanging from the roof and others all along the walls, while in the centre of the room sits a tall cylindrical-shaped drum. Her compound is busy with children, clients, friends and other family members. In her mid-sixties, Maama Maharage says she has been treating patients since she was 24. She became very sick, her breasts were discharging pus and she was brought to the hospital where they believed she had cancer. When it was discovered that she did not have cancer, her explanation was "*The spirits of my old father wanted me to be a healer*". She continues, "*So they (relatives) brought the drums and I have been treating patients ever since*". From the respect accorded to her, it is no doubt she is a powerful healer.

Through her collaboration with TAWG, she has received much information about HIV and AIDS. Since training, she is able to give health education and counselling to her clients when they come to her for treatment. Not only does she inform patients about AIDS, but she talks to the family as well. And though she is not a specialist on AIDS, she believes she has a remedy that is quite effective. She would like the hospital to refer patients to her so she can monitor them on this medicine. In the early days, she had difficulties talking to patients about AIDS, but now, with patients who know her well, there is no problem and she emphasizes prevention.

When patients come to her, the first thing she does is to consult the spirits and then give treatment. If the treatment is not working, she looks again at the 'X-ray' (spiritual consultation) that tells her this patient might need to go to the hospital. If so, she refers them.

Lessons learned from TAWG

TAWG is an important building block in bridging the gap between traditional and hospital medicine in order to assist people living with AIDS by providing available, culturally relevant and low-cost treatment. Key elements in the success of TAWG include the following:

- **Its knowledge of, and integration into, the communities with whom it works** has allowed a trusting relationship to grow between clients, staff, traditional healers and community members. TAWG has been active in Tanga for 11 years, has a caring and dedicated staff, and is well respected for its work.
- **The traditional medicine component is the foundation of the organization** and is what gives it its character. TAWG has combined ethnobotanical research, and prevention and care activities, enabling it to provide a comprehensive response to AIDS through a culturally and economically relevant approach. The strengths of both systems are combined in hospitals where traditional remedies collected by traditional healers are used by biomedical workers.
- **The respect given to traditional healers as health-care professionals has allowed for a trusting relationship to develop between them and TAWG.** TAWG has an agreement with the traditional healers with whom it works and both parties are very happy with the working relationship and see it growing and continuing.
- **TAWG's home-care programme** allows it to use its strength of combining traditional and biomedicine in a safe, confidential environment where counselling can also take place.

SUMMARY ANALYSIS OF TAWG

LESSONS LEARNED	MAIN COLLABORATORS	CHALLENGES	FUTURE PLANS
<ul style="list-style-type: none"> Traditional healers should be respected as health professionals Give traditional healers access to hospitals, clinics and patients Involve traditional healers in home care and training Healers care about their patients and want to learn more about research Traditional healers enjoy mutual referral between them and health-care facilities 	<ul style="list-style-type: none"> MoH Bombo Hospital African Orphans Aid Appeal (AOAA) Afriwag (NGO that helps orphans) CHAWATIATA (local traditional healer association) 	<ul style="list-style-type: none"> Social stigma associated with HIV/AIDS Only one traditional healer is supplying medicine to TAWG Lack of sufficient funds with which to expand the programme to involve more traditional healers Lack of sufficient research and documentation on traditional medicine Lack of sufficient collaboration and some negative attitudes from biomedical health practitioners Traditional healers in general have difficulty understanding research Traditional healers often do not trust each other 	<ul style="list-style-type: none"> Conduct clinical studies on the efficacy of the herbs found useful by TAWG Identify more herbal treatments for different diseases and conditions. Involve more traditional healers to supply herbs to TAWG clients Recruit more biomedical health practitioners to be part of the home-care team Train more healers as HIV/AIDS counsellors and community educators Sensitize more biomedical health practitioners on the value of traditional medicine Expand activities geographically

BEST PRACTICE CRITERIA ANALYSIS OF TAWG

Relevance	Effectiveness	Ethical soundness	Efficiency	Sustainability
<ul style="list-style-type: none"> Objectives clearly stated and based on 11 years of experience working with traditional healers Linking prevention and care in high-stigma context Providing STI and AIDS services in city market, a critical area for reaching women and youth Low-cost therapy in context where other options are limited Only service of its kind in Tanga, a remote region of Tanzania 	<ul style="list-style-type: none"> Clients and staff claim herbal treatment is effective for HIV-associated conditions 160 traditional healers trained since 1994 Drama group reached 55 000 people in 4 months CHICC has about 8000 visitors/month Surveys show that healers have increased awareness of HIV/AIDS Counselling helps clients benefit from treatment Clients who were counselled reduced risky behaviour 	<ul style="list-style-type: none"> Mutual respect is TAWG's main principle Counselled patients are given code numbers and confidentiality is assured International counselling standards are upheld; TAWG educates other counselling institutions in Tanga Patients have access to both traditional healers and biomedical health practitioners, and are referred as needed Traditional medicines have been used for generations, hence their safety and effectiveness are empirically documented MoH authorized research and provided offices within hospital Research results are fed back to healers and NGO 	<ul style="list-style-type: none"> In three years: 27 000 community members reached in education sessions 4300 home-care visits carried out to 237 PLWHA Herbal medicine is free for patients CHICC biomedical clinic run on cost-sharing basis Costs per patient treated are very low Administration of TAWG is strictly controlled and measures are in place to cut costs 	<ul style="list-style-type: none"> As permanent members of the community, traditional healers will continue to practice their new research and counselling skills even if TAWG is no longer present Healers do not receive salaries TAWG office is in the hospital; links between hospital and TAWG are strong Supervisors from nearby health facilities were trained to monitor and support traditional healers in their areas Capacity has been built in relation to HIV counselling

TAWG'S SPECIFIC CRITERIA/APPROACH FOR TRADITIONAL MEDICINE/BIOMEDICINE COLLABORATION

Criteria for selecting traditional healers	Approach used to build trust with traditional healers	Approach used to involve biomedical health practitioners
<ul style="list-style-type: none"> Being registered with the local traditional healer association (CHAWATIATA), which is under the Regional Culture Office Being recognized by the community as a traditional healer Programme Coordinator has knowledge of the community members Good performance, dependability, and consistent cooperation 	<ul style="list-style-type: none"> Give traditional healers time to observe programme and methods Promote mutual respect Plan programmes and reach conclusions together with traditional healers Healers appreciated being taken seriously and being treated like fellow professionals. Initial dialogue between expatriate physician, Tanzanian health workers and traditional healers evolved into a series of workshops on patient care, treatment, education and cooperation between biomedical workers and traditional healers Healers are paid for the medicine provided to TAWG (about US\$2/month/person) 	<ul style="list-style-type: none"> Biomedical health practitioners facilitate training of healers on STIs and HIV/AIDS, condom use and primary health care THs are encouraged to refer patients with complications to hospitals. There is also some cross-referral from biomedical health practitioners to traditional healers for counselling and management of other HIV/AIDS-related illnesses TAWG staff are clinical officers or nurses TAWG offered a three-day training to the district health management team

V. TRAINING, RESEARCH AND INFORMATION-SHARING ON TRADITIONAL MEDICINE AND AIDS: A COMPREHENSIVE APPROACH IN UGANDA

Background statistics: Uganda	
Total population in millions (1999)	21.1
Urban population (1998)	13%
Annual population growth rate (1990–1998)	2.8%
Infant mortality rate (1999)	103 per 1000 live births
Life expectancy rate (1998)	40
Total fertility rate (1998)	7.1
Literacy rate (1995)	Male: 74% Female: 50%
Per capita GNP (1997)	US\$330
National HIV prevalence (2000)	8.3%
<i>*Sources: AIDS in Africa: Country by Country, 2000, UNAIDS HIV/AIDS Surveillance Report, June 2000, STD/AIDS Control Programme, MoH, Uganda</i>	

AIDS in Uganda

Uganda, which once had the highest HIV prevalence rate in the world, is now mentioned by UNAIDS as the only country in Africa to turn a major epidemic around. In 1985, the Government of Uganda recognized the fact that AIDS affected all strata of the population and posed a serious threat to the socioeconomic development of the country. Since then, the national response has been characterized by a deliberate policy of openness, backed by effective political support from the highest levels of government. This response has borne positive results at both individual and institutional levels. Thus, the inclusion of HIV/AIDS in the Poverty Eradication Action Plan from ministries and districts to lower level plans and budgets; a high-level political commitment and advocacy; supra-sectoral coordination; community participation through NGOs, CBOs and religious bodies; as well as the greater involvement of PLWHA at all levels of planning and implementation have had a definite impact on awareness, stigma and behaviour at all levels of Ugandan society.

Today, AIDS knowledge in Uganda is almost 100% among adults. There has been an overall decline in HIV prevalence rates that had reached an alarming peak of 30% in some urban settings in the early 1990s and had steadily declined to 10–12% by the end of 2000 in the same surveillance sites. In 2001, the prevalence rate was estimated at 6.1% by the Ministry of Health. In some parts of Uganda, infection rates among teenage girls dropped dramatically during the 1990s, as did teen pregnancies. However, the number of teen pregnancies is still alarmingly high. The Uganda AIDS Commission states that, on average, 60 million condoms are being used annually by Ugandans.

Although Uganda has gone a long way in the fight against HIV/AIDS, the epidemic still poses a serious threat to society at many levels. Even at 8.3%, the overall HIV prevalence rate is still unacceptably high. Prevalence rates around the country are not declining fast enough and behavioural change needs to occur at a rate more in keeping with the increasing HIV/AIDS awareness. The high morbidity and mortality rates associated with the maturing of the epidemic places an enormous burden on already overstretched health and social services, and political will and enthusiasm do not always filter down to lower levels of government. The Government of

Uganda thus continues to call for everybody to participate in the struggle, within their means, mandate and capacity.

Traditional and Modern Health Practitioners together against AIDS (THETA): objectives and activities



At the peak of HIV prevalence in Uganda in 1992, health workers, families and communities were feeling overwhelmed and powerless against an enormous tide of health-care and prevention challenges. Yet, this emergency sparked a flood of new ideas in response, including the founding of THETA. With the support of the National AIDS Control Programme and the Uganda AIDS Commission, together with The AIDS Support Organisation (TASO) and *Médecins Sans Frontières* (MSF)⁴, THETA's work started in 1992 with two pilot projects based in Kampala. The first project aimed at evaluating traditional herbal treatments for some specific AIDS symptoms. The second project tested the effect of empowering traditional healers as STI/AIDS educators and

counsellors through training. Overall, these two projects, which lasted three years, yielded very encouraging results.

THETA's clinical study demonstrated that herpes zoster and chronic diarrhoea—both debilitating conditions affecting PLWHA—could be successfully alleviated by local herbal preparations. Two consecutive studies, consisting of systematic clinical observation and laboratory follow-up of more than 500 patients, supported this finding. As a result, many recognized AIDS clinics now advise their patients to use local herbal preparations rather than prescribing Acyclovir, the Western drug of choice for herpes zoster shingles eruptions. Acyclovir is imported, thus difficult to find, especially in rural areas, and unaffordable for most Ugandans. In order for these local preparations to be used more widely, THETA has piloted a herbal processing and packaging demonstration lab and has also initiated the growing of useful herbs at a herbal garden near its Kampala offices.

The THETA training programme has shown that traditional healers can be enthusiastic and effective community educators and counsellors for STI/AIDS through their ability to deliver preventive messages in unique ways, such as the use of personal testimonies, stories, song, dance, drama and proverbs. This programme was first piloted in Kampala, where its success elicited several requests from other districts for the programme to be expanded. By April 2001, nearly 1000 healers from seven rural districts had participated in a three-day AIDS awareness workshop, and nearly 300 traditional healers had gone through an intensive two-year training and certification programme in STI/AIDS counselling and education. This latter group has continued to engage disadvantaged communities in remote areas where no other AIDS educational activities had been initiated. Among various post-training initiatives, traditional healers conduct community AIDS education and individual AIDS counselling and care.

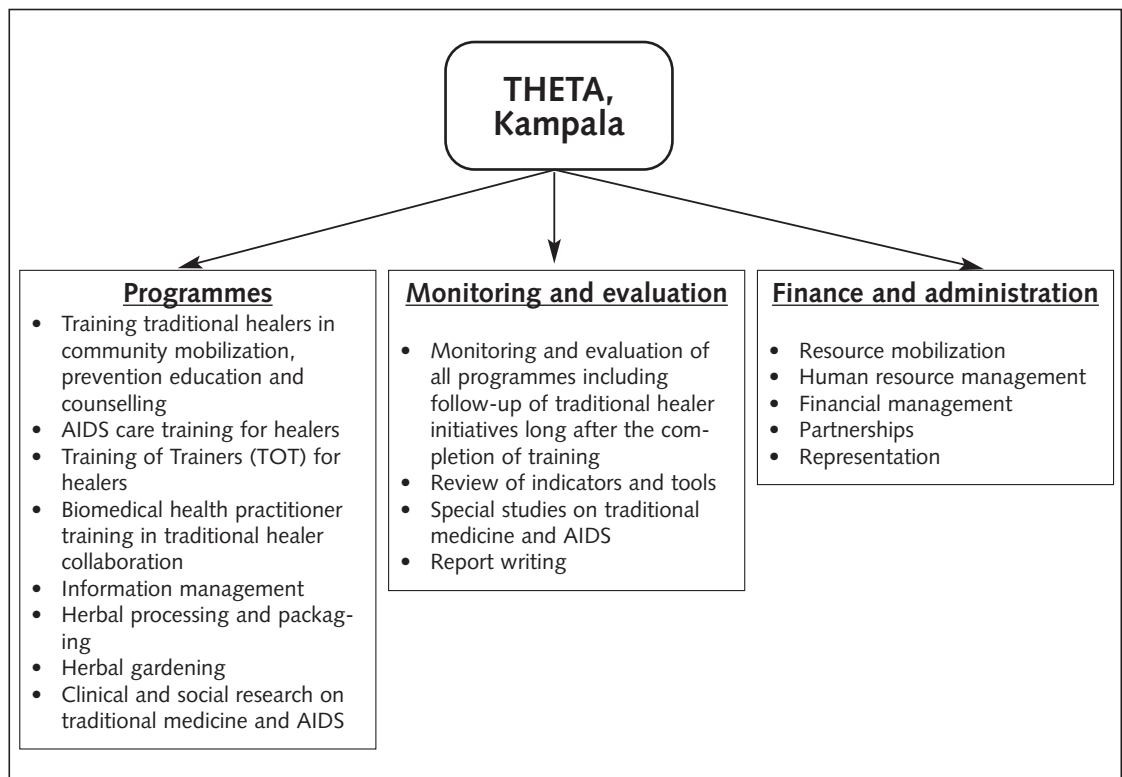
In 1995, THETA started a Resource Centre for Traditional Medicine and AIDS, which includes a library and speakers' bureau. The Centre facilitates the exchange of information and networking, both locally and globally. It has also published booklets, training kits, two informational/educational videos and a newsletter with a readership of over 500.

⁴ TASO is a Ugandan NGO started by PLWHA, their relatives and friends, who pioneered AIDS care and support in the mid-1980s. TASO is now active all over Uganda and has become a model and a main source of training that can be emulated in the region and the continent. *Médecins Sans Frontières* (Doctors without Borders) is an international humanitarian nongovernmental organization dedicated to assisting populations in danger due to natural or man-made disasters. Its interventions focus on public health emergencies and health assistance programmes worldwide.

THETA's success story attracted the attention of UNAIDS and, in February 2000, it was asked to host a regional meeting to discuss traditional medicine and HIV/AIDS in Eastern and Southern Africa. At this meeting, where 17 countries were represented, THETA was chosen as the Regional Secretariat of a Task Force aimed at developing collaboration between the traditional and modern health sectors for HIV/AIDS prevention, care and research in Eastern and Southern Africa. The mandate of this Task Force is to share information, advice and experience, to network, and to document best practices around traditional medicine and AIDS.

THETA's main goal is to improve and expand access to HIV/AIDS prevention, education and care for disadvantaged populations, such as women and children, through mobilization and the training of traditional healers in Uganda. The specific objectives are:

1. To train traditional healers in rural districts of Uganda in AIDS care, counselling and education
2. To improve knowledge, access and quality of selected herbal treatments for opportunistic diseases
3. To build the capacity of other NGOs and CBOs to enable them to work with traditional healers in AIDS prevention and care
4. To support healer HIV/AIDS initiatives in their own communities.
5. To collect, organize and disseminate information on traditional medicine and HIV/AIDS in East and Southern Africa.



THETA training for traditional healers in AIDS care, counselling, and education: what it entails

THETA's healer training began in 1993 as a pilot programme. It was confined to a small group of 25 healers in Kampala, with the aim of sharing ideas and information between the two health systems. In 1995, with requests from the Uganda AIDS Commission, and other NGOs, THETA extended its training programme to peripheral districts. The broad objective of this exercise was to empower traditional healers with information on AIDS and STIs to enable them to give good-quality education and counselling to their clients and community members.

Specific training objectives

1. To share information on sexually transmitted infections (STIs) and disease management practices, including the recognition of serious symptoms that require rapid referral.
2. To initiate and promote collaboration between traditional healers, biomedical workers and the community.
3. To equip traditional healers with effective communication, reporting, leadership and counselling skills.

Following a training cycle of two years, THETA holds a formal certification ceremony for healers, where community leaders are invited and healers have a chance to demonstrate what they have learned in the form of stories, personal testimonies, song, dance and drama. Subsequently, healers are followed up to support their post-training activities, to ensure sustainability and to document innovative healer initiatives. This process is lengthy, but it has bred strong ties between THETA and the healers who have been part of its programme. This aspect of THETA is key to its success. The important steps of this training cycle are outlined below and in the following diagrammes.

MAIN STEPS OF THETA TRAINING PROGRAMME

(1) Site selection and community mobilization

Several districts are visited and one is chosen based on specific criteria, including the willingness of health workers to collaborate with traditional healers, the lack of similar HIV/AIDS services, and the level of interest of district officials in supporting the programme after THETA pulls out.

Mobilization workshops are then organized at the subcounty level. They usually last one day and include about 100 traditional healers, elders, community and religious leaders and other resource people. The aim is to introduce the objectives of THETA, and to share AIDS and STI information.

(2) Baseline traditional healer KABP survey and community assessment

A baseline assessment is carried out by community interviewers to determine communities' knowledge, attitudes, beliefs and practices (KABP) towards HIV/AIDS and traditional medicine. A KABP questionnaire is administered by the community interviewers, with the supervision of social scientists, to 100 randomly selected healers in each subcounty.

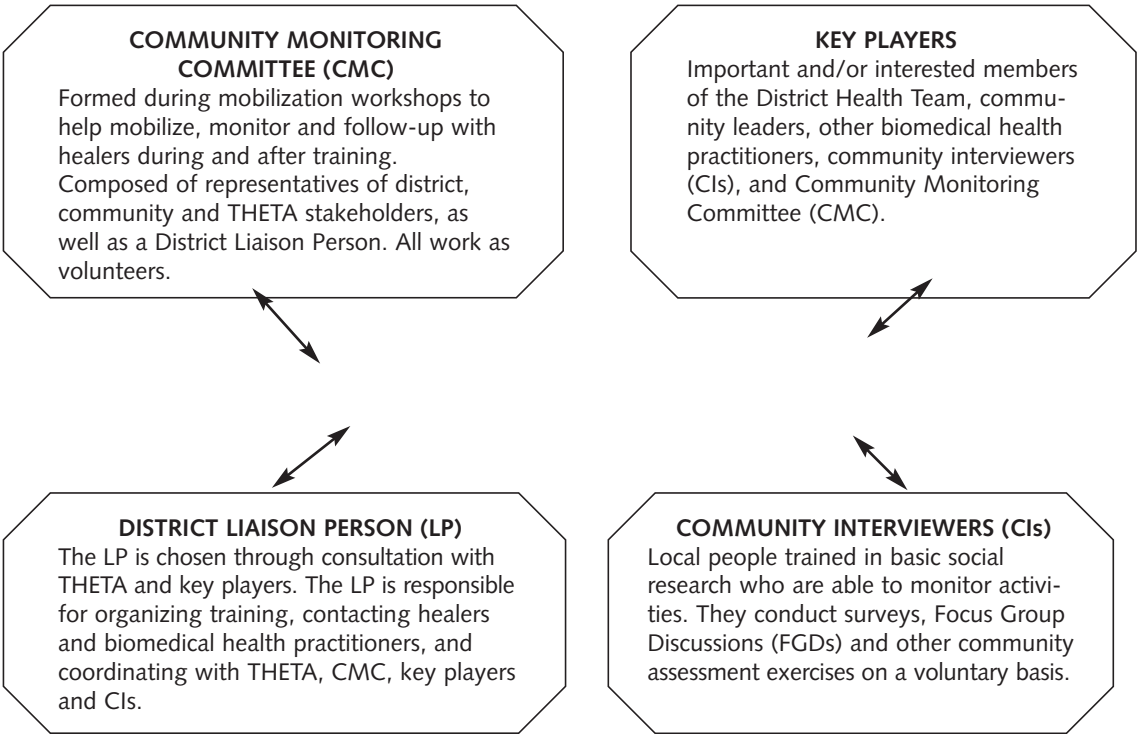
(3) Training of traditional healers, biomedical health practitioners and community representatives

Traditional healer training is conducted in two phases. Initial training is given three days a month for six months and is aimed at giving healers basic facts about STIs, collaboration, counselling and patient care and support. THETA trainers use this period to create rapport and to learn more about healers' knowledge, attitudes and practices towards HIV and AIDS. The second phase of training is intended to enhance collaboration and further develop skills in community AIDS education, counselling and referral, and includes field visits to local AIDS NGOs and hospitals. Biomedical health practitioner training workshops also take place regularly and are aimed at promoting collaboration between traditional healers and biomedical health practitioners. The Community Monitoring Committee (CMC) and Community Interviewers (CIs) are trained in community mobilization and social research respectively.

(4) Monitoring, evaluation and follow-up

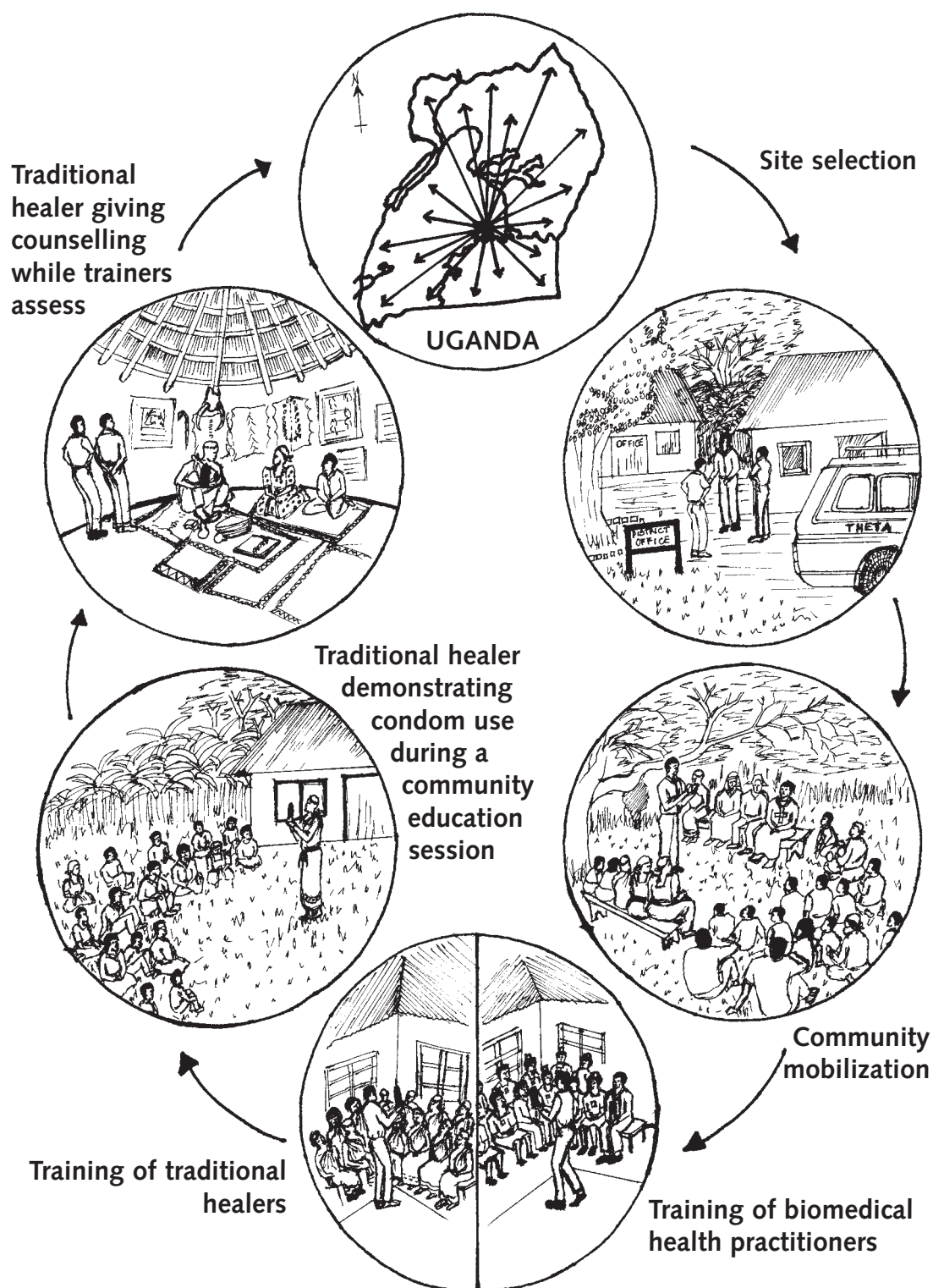
Process evaluation includes site visits to healer clinics, as well as focus group discussions with community members, including untrained traditional healers. Dissemination of key findings takes place during regular meetings with stakeholders. The THETA training team visits key players on a regular basis to encourage their support of healer activities to ensure sustainability. A final assessment takes place to determine which post-training activities healers have excelled in, and covers a post-training KABP survey, oral and written tests and trainers' input. Healers are then certified in community education, counselling and collaboration, or a combination of the above. After training, THETA conducts one-to-two-day follow-up visits quarterly, while CMC and CI support is offered regularly. Impact and sustainability are assessed by reviewing reports and collecting additional information from programme stakeholders in a final evaluation.

THETA District Outreach Programme Community Structures



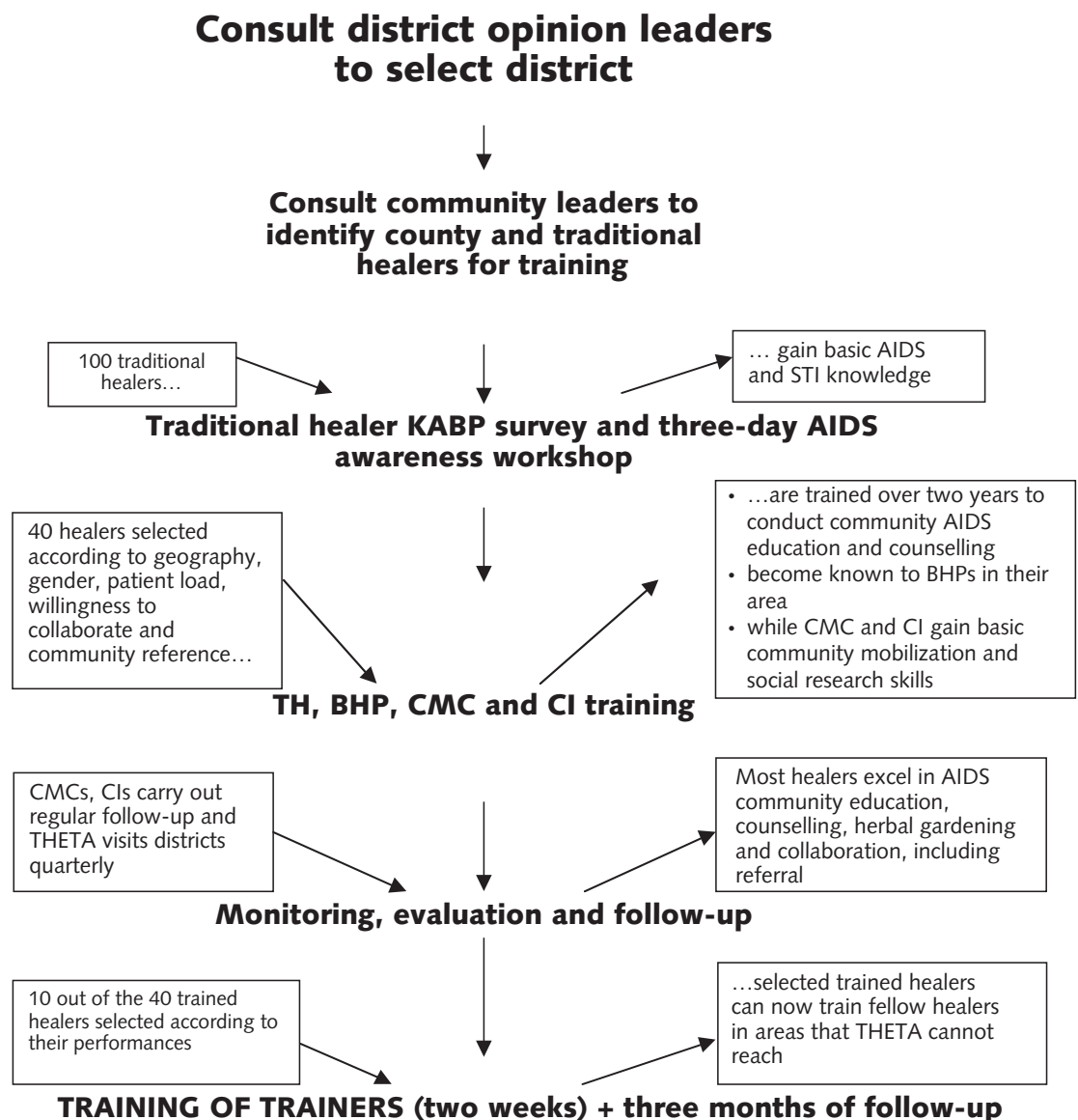
THETA training cycle

HEALERS IN THETA TRAINING PROGRAMME



The THETA training cycle lasts two years. Site selection and community mobilization last three-to-six months, including a KABP survey and community assessment. Training is spread over 18 months, with the first six focusing on information sharing, and the last 12 emphasizing collaboration and skill development. Training targets traditional healers as well as biomedical health practitioners, the Community Monitoring Committee and Community Interviewers. Monitoring and evaluation of the process takes place throughout the cycle. Post-training follow-up is conducted through quarterly visits and through the support provided by the CMC and CIs. Impact and sustainability are assessed through participatory evaluations.

THETA traditional healer AIDS education and counselling training programme and outcomes



Outcomes of traditional healer training in AIDS care, education and counselling

Traditional healers trained by THETA have added to the group of fighters against AIDS.
(Community leader, Hoima, 2000).

Before THETA initiated activities in the districts, healers reported that they were doing little or nothing regarding AIDS and that they did not see AIDS patients. Healers were often known for their witchcraft and rarely cooperated with each other or the biomedical health services.

Over the last nine years, THETA has enrolled and certified in its four-year training programme almost 300 healers in AIDS prevention and care in eight districts of Uganda (Apac, Hoima, Kampala, Kamuli, Katakwi, Kiboga, Mbarara and Mukono). In addition, THETA has sensitized almost 1000 healers in numerous districts in three-day STI/HIV/AIDS sessions. To date, traditional healers trained as trainers by THETA have also reported training over 200 other healers in AIDS prevention and care. THETA has involved over 100 biomedical health workers in the collaboration.

Following training, healers are offering a range of new services, such as AIDS community education, counselling, home visits, condom distribution and improved patient management using referrals among themselves and to health units. Some healers have also embarked on herbal gardening and combined biomedical/traditional medicine clinics as a result of training.

Community AIDS education by traditional healers: a popular and interesting community event

Community education was not part of THETA's initial plan. But healers trained by THETA felt the information they received was important for other healers and their clients. One healer explained that everyone should have a similar understanding of risky behaviours so that if he counsels a client who then goes out into a community that does not have the same information, the client may get confused. "So," he said, "we were forced to start educating our communities."



Traditional healer giving community AIDS education

According to THETA's 1998 Evaluation Report, community members from many districts have commented that they only believed the information about AIDS when they heard it from the traditional healers. This highlights the critical role healers play in the community:

The information about AIDS used to be rumours in my ears; today, I got the privilege to hear from my healers some information that is going to help me save my life.

—Community member, Katakwi

Because I am still young, I can protect my life using condoms, and spacing my children.

—Community member, Kiboga

A typical traditional healer community education event begins late in the afternoon, at around 3pm. People converge usually under a mango tree, at a school or somebody's home, their numbers continuing to grow as the event unfolds. Usually conducted by a team of three or four traditional healers trained by THETA, the session begins with introductions of the healers, community leaders and guests, and is followed by the programme of the day. Generally, topics discussed in community education include the impact of AIDS on the community, the difference between HIV and AIDS, HIV transmission and prevention, stages of HIV infection and positive living. Since the healers conduct AIDS education in teams, a point missed by one is usually caught by another. Community education is participatory and the methods used usually include brainstorming, question-and-answer sessions, music and drama, personal testimonies, use of posters and condom demonstrations. The local language is used, including proverbs and stories. Community education events sometimes run late into the evening, depending on the need for community counselling or clarification of an issue.

Many times traditional healers have emphasized that HIV/AIDS kills, and they will always emphasize taking your child for testing. Traditional healers advise and insist that each of their clients brings his/her own razor blade.

—Community member, Mbarara

Healers describe their role in educating their families and communities, not only about AIDS, but about other important health issues:

We have started to educate people on the importance of hygiene in homes.

—Trained healer, Mukono

This information (AIDS) is very useful to my family, especially my adolescent sons, and I no longer fear looking after a person with HIV.

—Trained healer, Mukono

I work together with fellow healers to educate the communities. When there are many of us, we can handle all the questions.

—Trained healer, Kiboga

By June 2000, 1503 people had been reached by traditional healers in community education events in one THETA outreach district (Hoima, 2000). By extrapolation, it can be estimated that over 10 000 community members have been reached by THETA-trained traditional healers in eight districts of Uganda. And in both Hoima and Kamuli Districts, of the 100 community members interviewed in the end-of-programme assessment, 62% and 61%, respectively, had heard traditional healers giving AIDS educational sessions during which they talked about HIV transmission and prevention methods, emphasizing condom use.

Byooya Deogratius: Traditional Healer, Mbarara District



It is a Tuesday morning and 'Dr' Byooya is in his clinic—a small mud room in a bustling market in rural Kashari County, Mbarara District, Western Uganda. The sun shines brightly outside, but inside it is cool, calm and dimly lit by only a small window. The room is divided in two by a temporary bamboo wall that provides a confidential examination area on one side and a waiting, consultation, and herbal display area on the other side. There are five people, men and women, young and old, waiting inside, and two outside. A grey-haired man is kneeling in front of the healer, finishing his consultation. The healer

explains how to use the herbs and notes in his record book what the patient is suffering from, the name of the herb given and the dosage. A woman with a baby goes to wait in the 'examination room'.

The traditional doctor is old by Ugandan standards—67 years—and he has grey hair and wears a white coat, implying that he deserves respect. Not only is he a healer and a traditional birth attendant, but he grows bananas and coffee, and has a herd of cows. Dr Byooya also serves as a community leader. Married with 17 children, he started practising in 1946, through what he termed 'a natural inheritance'. His grandfather was also a healer and said that when the missionaries came to ban traditional medicine, the spirits protected him. When Dr Byooya's sister fell sick, he dreamt of the herbs to cure her and they were the same herbs that his grandfather used. After treating his sister, he became a practising healer. But, in 1963, his 'spirits got away' and he could no longer practice, so he worked for the Ministry of Works as a road inspector for 17 years. Then, in 1983, again during sleep, the spirits came to him and told him that his work was not the roads; he should go back to treating people. He soon became a very famous healer as a result of his treatments and by training other healers in hygiene and new herbal treatments.

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There have been challenges in his practice, including the fact that he does not have packaging equipment and supplies for his herbs, and his cows constantly spoil his herbal garden. He would like to fence it.

THETA training has changed his methods of diagnosing patients because he now knows the symptoms of AIDS and he can tell through counselling what they are suffering from. The main change in his 'job description' before and after THETA is his record-keeping. He notes down the name of every patient he sees. On average, he sees about 10 clients a week for diarrhoea, worms, enlarged liver, cough, madness, fever, trouble with child birth, impotence, nose bleeds, syphilis and HIV/AIDS. The diseases he cannot treat, such as TB, HIV/AIDS and enlarged liver, he refers to the hospital. In fact, one of the patients waiting has a brain disease and he has been trying to treat him, but has also referred him to the hospital for medication. So this young man is getting both traditional and biomedical treatments.

Dr Byooya has noticed some significant changes in the community since the arrival of THETA, namely that his patient load has increased because community members trust the trained healers more than untrained healers. Trained healers have been uniting for different projects such as community education events and they have come together to plant a herbal garden. They have also proposed building a traditional medicine centre on land given to them by the Local Council.

When patients come to Dr Byooya for consultation, he takes that opportunity to give them information on HIV and hands out a pamphlet published by the National AIDS Control Programme called, *Questions and Answers about HIV and AIDS*. In addition, he used to get condoms from the health centre and distribute them. However, he has recently been in an accident and cannot walk, so his community has been disappointed that he no longer has condoms to give away. It is mostly the youth who come to ask for condoms, but he also noted that, *'The big men also come asking me for condoms'*.

Healers counsel their patients

Traditional healers who have learned about the benefits of AIDS counselling, have quickly integrated their new skills into their old practices. In all the THETA districts, traditional healers have appreciated learning about AIDS counselling and are applying it in helping to diagnose patients' problems, as well as supporting clients in prevention of HIV and care for PLWHA and their family members. For example, in the end-of-programme survey in Hoima, 93% of traditional healers said that they talk to their patients about AIDS, compared to 81% before the programme began. The most common information given to patients, both before and after the programme, is related to taking HIV tests (THETA reports, 1999).



Traditional healer in family counselling session

Counselling helps the healer to establish the cause of disease without using the spiritual powers; it helps you explore clients' feelings and gives clients a chance to make decisions and plans

—Traditional Healer,
Follow-up visit, Hoima, 1999

We counsel AIDS patients so that they avoid getting too worried or committing suicide. We counsel those who are not sick so that they can change their behaviour to avoid HIV infection

—Trained healer, Kiboga,
THETA Evaluation Report, 1998

Gertrude Lukowe: Traditional Healer, THETA

Widowed, 54 years old and a mother of seven, Gertrude is one of the traditional healers who have been trained in Mukono District. A slender woman, Gertrude is both a spiritualist and a herbalist. She specializes in treating impotence, miscarriages and jaundice.

Since the beginning of THETA training in May 2000, Gertrude has learnt how to take better care of her herbs, and herself. She now discourages sharing sharp instruments and razor blades in her 'clinic'. *"I have learnt a lot about HIV/AIDS and other STIs, how to prevent them and care for patients, and also how to use condoms,"* she says.

Gertrude describes a typical scenario with her clients: *"As the patients come to my clinic, I first take particulars of where they are from, their age and family background. I listen to the patients as they explain their problems. My patients have a choice on the type of diagnosis, whether through spiritualism (using the ancestors) or by me. Depending on how patients explain their illnesses, I take the opportunity to counsel them about the dangers of STIs and HIV/AIDS. I give my patients herbs already mixed and I determine the dosage depending on their condition."*

On how she has benefited from the training, she says THETA has brought healers closer to bio-medical health workers. *"I can now use gloves like other health workers and I am now respected by them and the community,"* she boasts. In addition, she says, now that she is quite knowledgeable in AIDS care, she shares what she has learnt with untrained healers.

Gertrude is deeply involved in counselling and referral of clients. She refers patients with complications of fever, diarrhoea and severe headaches to the subcounty health centre.

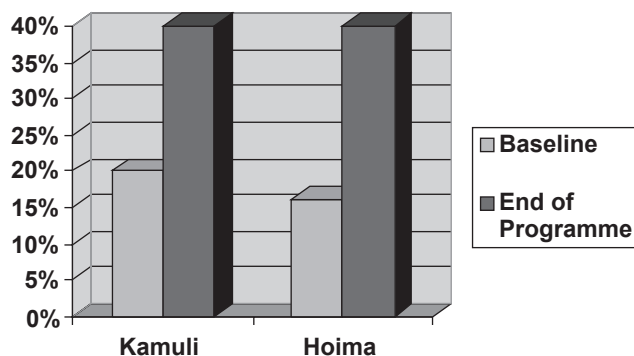
Gertrude is challenged by the lack of cooperation on the part of fellow healers. *"Everyone works on his/her own. We need to open up and share knowledge about the different herbs that we use to treat patients,"* she emphasizes.

How do traditional healers take up the job of condom use and distribution?

In the past, it was difficult for health workers to distribute condoms because they didn't have ways of reaching communities; now trained healers do the work (THETA Evaluation Report, 1998).

As an example, in two of the THETA outreach districts, the increase in condom use among traditional healers themselves is reported in the figure below. In Kamuli, reported use of condoms (i.e. not necessarily regular use) among healers increased from 20%, before the training, to 40% two years later, after the THETA training programme. In Hoima, the increase was from 16% to 40%.

Reported 'ever use' of condoms by traditional healers in two outreach districts in Uganda before and after THETA training programme.



A traditional healer in Mukono District receiving condoms from a THETA Trainer

my role of information-giving, and when they go back they share with others and refer their friends to me. The biggest concern of my clients is the durability of the condoms and misconceptions such as the rumour that the virus is inside condoms. Many community members that come to me already know that I distribute condoms, so they are sometimes shy at the first visit, but upon subsequent visits become open. My condom clients are mostly young people, boys who come often in the evenings and on weekends. Yet, some people come at odd hours in the night for condoms and often pose as visitors because openly talking about sex is still a problem. I have to invite them into a private room as I cannot demonstrate how to use a condom with a penis model in the open. We also have to discuss condom negotiation with their partners.

Have traditional healers improved their patient management through training?

Fifteen out of 20 (75%) trained traditional healers interviewed in one THETA district keep records of patients. All THETA-trained healers reported using the skills they learned in patient-care training, as well as referring patients to biomedical facilities. Healers were able to describe common STIs, as well as serious clinical signs that need immediate referral to hospitals.

If I get a patient complaining of abdominal pain, I check where the pain is and you may find that he/she has a hernia that needs an operation

—Traditional healer, Focus Group Discussion

The THETA 1998 Evaluation also found that in communities with a THETA-trained traditional healer, community members were more aware of condoms and more people understood that condoms are effective in blocking HIV than in communities where there was no trained healer. Community members recognized that they could get information and condoms from a trained healer.

We get condoms from Kavuma, the healer.

—Community member, THETA Evaluation Report, 1998

The community is now consulting us on condoms and AIDS-related information. Even the clergy is beginning to consult us.

—Trained healer, Kamuli Status Report, 2000

In one THETA district, the proportion of healers who reported discussing condoms with clients increased from 68% to 90% after the THETA training.

One Kampala healer, Musa Mutebi, talked about his experience in condom distribution:

Clients come to me with physical and spiritual problems. I use a relationship problem as my entry point to introduce condoms. We discuss condom use, disposal and some of the misconceptions. Clients have appreciated

We are now aware of danger signs on patients who need immediate referral to the hospital, e.g. difficulty in breathing.

—Traditional healer, Focus Group Discussion

One medical officer noted that training had helped traditional healers understand their professional environment, and this has allowed healers to express their views openly with biomedical workers. Secondly, as traditional healers have been exposed to the concept of modern medicine, they have learned that both modern and traditional systems are acceptable and important. This has encouraged openness and referral not only around HIV and AIDS, but for many other health issues.



As an example, one healer noted that:

THETA has taught us about TB and HIV/AIDS. We never knew that TB is spread through inhaled air. THETA has taught us about condoms and their use. They revealed to us every method in the spread of HIV/AIDS.

—Traditional healer, Kiboga, THETA Evaluation Report, 1998

One biomedical health worker described trained healers' work:

Traditional healers carry out home visits to their clients, which is not common among medical workers. When they visit, they talk at length with clients, and they encourage and support them in many aspects.

—Biomedical health practitioner in charge of NGOs, Kiboga, THETA Evaluation Report, 1998

Since training by THETA, both healers and biomedical workers are referring patients to each other. Trained healers have learned to take advantage of the strengths of biomedical health facilities.

I refer for checking the blood. It becomes easier to give follow-up treatment instead of just watching someone grow thin and saying it looks like 'slim,' on speculation only. That is why referral is good.

—Trained traditional healer, Soroti, THETA Evaluation Report, 1998

In one THETA district, referral increased from 58% at baseline to 90% at the end of the programme (Hoima progress reports, 2000).

Other NGOs, such as local testing-and-care centres, have reported that healers refer clients to them for testing, counselling and care. Biomedical health workers have also realized the value of traditional medicine:

There are people with symptoms that we treat and they don't respond, so we refer them to traditional healers. In fact, the THETA training has helped, because sometimes we can run short of drugs, so we refer the patients to traditional healers.

—Biomedical health practitioner in charge of health unit, Mbarara, THETA Evaluation Report, 1998

Referral helps the healer, the patient and the caretakers because all of these parties build confidence in each other. You avoid being considered as a dishonest person. With time, you get more patients because they trust you.

—Trained traditional healer, Mukono, THETA Evaluation Report, 1998

In collaboration with biomedical workers and traditional healers, THETA has designed and translated a referral form that is now being used by traditional healers and has eased the process of referral to health units. The form was introduced and discussed with both traditional healers and biomedical health practitioners in a joint meeting. After only a few months of use, the response has been highly positive and the number of forms collected from health units has increased.

Healers now help health workers mobilize resources for health promotion activities like National Immunization Days. Kiboga District Hospital has given healers space to treat patients and there are periodic joint community-education events by healers and health workers.

Mugume Yorokamu: Clinical Officer, Mbarara District



Mugume is one of the few clinical officers in Uganda who are very open about collaborating with traditional healers. He has been working in Kashari county, Mbarara District for three years and, upon his arrival, found that the healers were highly organized. He was soon appointed an adviser to the newly formed traditional healer organization.

Prior to working in Kashari, he was also working with the Mbarara University Mental Health programme. It also collaborated with traditional healers, and he noted that most patients with mental illness consulted traditional healers.

He explained his motivation for collaborating with healers by simply stating that they have many patients and those patients are also 'our patients'. *"We share them and the healers do a lot of counselling as well."* Healers also refer patients to him because they know him. He has appreciated the exchange of ideas with healers and has learned about some useful herbal medicines that he has planted in his garden.

Recently, when he visited one healer, he found a girl at the healer's clinic with a deformity. She had spinal TB. The healer referred her and she is now improving on a combined traditional medicine/biomedicine treatment. He has found that many patients with HIV-related conditions have been helped by both oral and topical herbal therapies. And healers have been good about following up with these patients to see if they are improving or getting worse.

He has found the greatest challenges in this collaboration have been that health workers do not have access to healers and that untrained healers do not refer patients.

In the future, he would like to see healers uniting in order to improve on their medicine and make it more accessible to patients. He noted that, *"We cannot facilitate healers as individuals to improve their medicine, but when they come together, we can really do something!"*

Healers training fellow healers—a challenging initiative

One Kampala healer explained that traditional healers trust their fellow healers more than their biomedical counterparts and are therefore more likely to listen to them as trainers. Healers are



A traditional healer in Mukono District receiving condoms from a THETA Trainer

taking up the challenge of training their fellow traditional healers who did not participate in the original THETA programme. Through the TOT programme, THETA has provided selected traditional healers with a training kit that includes pictures and explanations of different concepts related to HIV, AIDS and STIs, as well as a trainer's guide, all in local languages. Some healers are more active than others in this realm. Healers who have been particularly dynamic claim that they are motivated by the positive response to their training. Healer-trainers have conducted multiple training sessions that cover a range of topics, including patient management, transmission and prevention of HIV/AIDS, TB and family planning. The training kit and guide help traditional healers organize their training sessions. In Kiboga District, community leaders donated two bicycles to traditional healers in recognition of their hard work in training.

It is an achievement for trained healers to train fellow healers.

—Community Interviewer, Kiboga, THETA Evaluation Report, 1998

A THETA senior trainer explains that it is a big step for traditional healers to go from training community members who, in general, have very little technical information, to training fellow healers,

especially in planning and organization. In addition, sometimes healers do not like to see other healers appear more knowledgeable or powerful than themselves.

Healer organizations and associations

THETA-trained healers in Kiboga have formed an association—KITHETA—that includes health workers, community leaders and non-THETA healers to strengthen their activities. They have links with the district departments and they have opened up an office for counselling and herbal treatment. Improved services have led to increased numbers of clients and, thus, increased household incomes.

In Mbarara, traditional healers formed two organizations. One is comprised of trained healers and the other includes both trained and untrained traditional healers, and spearheads activities such as bee-keeping, a savings and credit scheme, and herbal gardening on four different plots.

Healers in Kamuli have organized themselves into a group with the objective of continuing activities relating to community education, counselling, information exchange on effective herbal remedies, and income-generating activities such as brick-making, fruit growing, pig and poultry farming and bee-keeping.

Collaboration between traditional and biomedical health workers: what does it entail?

Collaboration, as an outcome, is difficult to measure, but some indications of increased collaboration include the changes in attitudes of modern health workers and community members towards traditional medicine, referrals, site visits, or simply an increased interest and motivation in working together for the benefit of clients and communities.

THETA has done a good job mobilizing healers to come together. It has tapped healers' skills and knowledge, and increased information and communication in communities, especially those where medical workers don't go.

—Medical Superintendent, Kiboga, THETA Evaluation Report, 1998

THETA services are required; it was nice to start this programme because previously there was no collaboration. We didn't even know that healers were treating people with these conditions, but now there is a forum where we can exchange ideas.

—District TB/Leprosy Supervisor, Kiboga, THETA Evaluation Report, 1998

Trained traditional healers are even involved in health committee discussions.

—Biomedical health practitioner in charge of health unit, Mbarara, Evaluation Report, 1998

In one district, healers increased their collaboration from 67% at baseline to 91% in the end-of-programme survey. The main type of collaboration is patient referral, receiving condoms and seeking advice from their biomedical counterparts (Hoima reports).

Muhindo: District Liaison Person, THETA



A Clinical Officer with Nakifuma Health Centre, Muhindo also doubles as the THETA Liaison person in Mukono District.

Muhindo has a lot of experience to share. As a health worker, he feels traditional healers have filled the gap by referring patients rather than allowing them to delay before receiving proper care. Initially healers did not value referrals of complicated illnesses, but after their training, there was an increase in the number of patients referred to the health centre.

He confesses that before working with THETA, he had never been to a shrine and he did not have the slightest idea how healers worked. The first time he visited, he was frightened but, after more interaction through THETA, he feels healers have become friends and partners in health service delivery.

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Muhindo says healers have changed the way they manage patients. They now carry out elementary clinical diagnosis, especially for STIs such as syphilis, which is quite common in their communities. They can easily tell the difference between febrile convulsions due to malaria and those due to epilepsy, which they initially thought were spiritual illnesses. They are quite interested in the training and they are greatly inspired by the collaboration they now have with biomedical health workers. Early on in training, healers did not want to disclose their methods of diagnosis and treatment. Now, some healers keep records of their patients, the history of the illnesses, how they are treated and with which herbs. They often disclose which herbs they know about to other family members for continuity. *"In fact," he says, "there are five traditional healers I know of in Nakifuma who are documenting the herbs they use for different illnesses."* Traditional healers also have referral forms that brief clinical officers on the clinical history of patients.

Muhindo is actively involved in training, follow-up and support supervision. Through Muhindo's influence, healers have been included as part of the community-based health team for the sub-counties. They have been added to the list of community workers, which includes traditional birth attendants and community health workers.

Muhindo says he has been greatly motivated by THETA's strong community-based approach. The seriousness of the programme and the way THETA is following up with the healers have inspired him. *"You feel you are working with people who are enthusiastic about what they are doing,"* he says.

Additional training outcomes . . .

Traditional healers have reduced the charges for their services.

They are honest, and ask for reasonable money compared to the previous exorbitant charges, which showed greed.

—Community Interviewer, Kiboga, THETA Evaluation Report, 1998

As a result of the training, 70% of traditional healers have improved the hygiene of their work places. Traditional healers have started constructing pit latrines, and refurbishing their shrines and homes.

The healer's shrine is neat and nicely built. It has a lot of cultural heritage. The box of condoms is beside him with a dildo made of cheap wood.

—Counsellor, Kiboga, THETA Evaluation Report, 1998

Dr Donna Kabatesi: Director, THETA



Donna is married with two children and has been the director of THETA since the very beginning. She says that before she started with THETA she was curious about the work of traditional healers and did not know what to expect. She had heard lots of stories and had many misconceptions. She thought that no good could ever come out of the work of such healers. When she entered a healer's shrine for the first time, she was very impressed by the number of people waiting for treatment and thought: *"If this is rubbish, all these people would not be here..."*

From that moment on, her curiosity increased, but the first three months of THETA were discouraging and frustrating as many of the healers were initially indifferent to the idea of collaboration. One of the healers asked her, *'What are you doing here? I don't treat people with AIDS.'* Donna explained that he did not want to have anything to do with THETA, and was afraid of dealing with AIDS. He said, *'I'm a very busy man.'* Yet, with time, this healer has become one of THETA's closest collaborators. Subsequently, the healers' response has been overwhelming, as this is an area people have not paid much attention to. Many people train community health workers, but nobody

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has taken the idea of training traditional healers seriously, yet healers are willing and are present in most communities. They come around in only a few months with great enthusiasm. What the healers have been able to do with very basic information has been Donna's greatest source of motivation and inspiration. She says, *"I haven't seen that anywhere else; in general they are not educated, THETA gives them so little, yet they have done much more than we ever expected."*

Donna says there are many things she has learned in the last nine years working with traditional healers. They respond to values that Western-trained medical personnel ignore and are insensitive to. Healers understand where their patients are coming from and treat them as human beings, which is their strength. She has learned that it is not only what you give a patient that matters but also how you treat the patient, and that what surrounds the patient is just as important as the disease diagnosis. She says she has been humbled, having realized that biomedicine offers a very narrow and incomplete approach and that, *"Despite its limitations, traditional medicine is more complete in its response to the broad definition of health"*.

The advice Donna would like to give to others who might be interested in initiating a similar collaboration is to start with no assumptions, and to approach traditional healers with an open mind. Some aspects will work and others will not. One must start with the idea that there should be a significant time investment if the project is going to pay off. Despite the fact that difficulties may be similar in many countries, a THETA-like programme will follow different courses in different contexts. She feels one of the biggest challenges is to try and organize traditional healers from the outside, but that the impetus must come from the healers themselves.

Donna sees the future of THETA as that of a reference organization—other organizations can come, learn and share; THETA can assist healers and find better ways of approaching difficult issues. Healers treat common health problems (not just AIDS) and their focus is not restricted to health and disease. Many traditional-healer clients consult healers for social problems as well. Donna recently visited a healer who was being consulted by a client who complained that her co-wife had put a spell on her. The traditional healer provided treatment and harmony was restored in the household.

Lessons learned from THETA

After the completion of the THETA training programme, healers in every subcounty of THETA outreach districts have started a new AIDS-related activity, including: training of other healers, community AIDS education events in collaboration with other health educators, herbal gardens and combined traditional healer/biomedical practitioner clinics. Healers are also increasingly interested in organizing themselves into associations to share ideas and to work together for these new initiatives.

According to THETA programme leaders, it is important to remember that the following key elements act in synergy with each other. None of these elements alone would be enough to ensure the success of the programme.

- **Respect for healers as legitimate health-care providers generates trust.** Healers have a long history of not being respected by colonial governments, missionaries and the biomedical health-care system. When THETA approached them with a genuine respect for their profession and their work, the relationship started off on a positive note. THETA also relates to healers with openness, and tries to convince others of the value of traditional healers, which instils increased self-confidence among healers.
- **Involvement of community leaders in the implementation and follow-up of training activities.** Including community leaders from the moment THETA begins its activities in outreach districts has allowed for a community ownership, interest in sustainability, and increased collaboration at all levels.
- **Integration of biomedical health workers in the training programme allows for a relationship to be built between traditional healers and biomedical health practitioners for future collaboration, including cross-referrals.** As biomedical health practitioners from THETA and local health facilities take part in the programme and are targeted in the same way as healers, the

latter are able to build a relationship with them and trust them enough to refer patients, consult on medical issues and continue an open dialogue.

- **The length of the intervention allows THETA and healers not only to build a trusting relationship but to strengthen each other's capacity and sustainability, while cultivating a genuine interest in each other.** At the outset, four years can seem like a long time, but the intensive training only takes place during the first six months. The remaining time spent on follow-up is important to reinforce concepts and to learn from traditional healer initiatives that sometimes only start long after training is completed.
- **A strong monitoring and evaluation component throughout implementation and follow-up** has allowed THETA to keep track of what is going well and what needs improvement, and to identify determinants of success and failure. It has also allowed for reflection on its aims, goals and vision for future planning.

All these elements have resulted in increased self-esteem of healers as they have taken on new roles and responsibilities in their communities. Community leaders and members have shown additional respect for them as well.

SUMMARY ANALYSIS OF THETA

LESSONS LEARNED	MAIN COLLABORATORS	CHALLENGES	RECOMMENDATIONS/FUTURE PLANS
<ul style="list-style-type: none"> • Research with healers requires mutual respect and collaboration with biomedical health practitioners • Collaborative work requires time to build trust and continuous follow-up to monitor and evaluate a changing epidemic, and a dynamic relationship between the two health sectors • Mistrust between the two sectors was greatly reduced during training • Healers can come up with innovative ideas for AIDS prevention long after training is completed • This type of collaboration can extend nationwide if strong links are built at the community level with local leaders, key government and nongovernmental players and health authorities • Healers make diagnoses based on beliefs, not on a scientific basis, and their interpretation of diseases is not uniform among them • Healers are eager to learn from biomedical health practitioners • Traditional healers often attribute nutritional disorders to witchcraft • Traditional healers are well known for treating mental disorders 	<ul style="list-style-type: none"> • AIDS Information Centre (AIC) • MoH-NACP • The AIDS Support Organization (TASO) • Uganda AIDS Commission • MSF 	<ul style="list-style-type: none"> • Low literacy levels of healers affected their ability to learn. It was challenging to devise appropriate training methods for non-literate healers • Due to translation, training often took longer than expected in districts where trainers could not speak the local language • Talking to clients about AIDS is still challenging to some healers in some districts • Healers complained that long intervals between THETA follow-up visits made them forget what they had previously learned • During follow-up visits for AIDS patient-care training, it was difficult to assess healers because trainers often did not find any patients at the healers' clinics • Some local leaders took a long time to appreciate healers' potential and the value of their post-training activities, and were hesitant to commit financial resources to healer work plans 	<ul style="list-style-type: none"> • Healers should be provided with well-designed referral forms • Biomedical health practitioners must be sensitized to the need for monitoring of referrals • Healers should identify a local biomedical health practitioner to whom they can refer patients, and from whom they can get feedback on the patient's progress • Referral should be a two-way process • A clinic where healers and biomedical health practitioners work hand-in-hand should be set up • THETA's Patient Care Training for healers should address the fact that healers would like to learn how to perform more clinical procedures (use a blood pressure machine, give injections, set up a drip) • More lectures should be offered to healers in the hospital setting so that they can observe procedures

BEST PRACTICE CRITERIA ANALYSIS OF THETA

Relevance	Effectiveness	Ethical soundness	Efficiency	Sustainability
<ul style="list-style-type: none"> Objectives are clearly stated and based on baseline healer surveys and community assessments Objectives follow the National AIDS Control Programme strategy Implementation of district activities is area-specific and based on feasibility assessments conducted in several sites before new districts are chosen 	<ul style="list-style-type: none"> 861 healers have undergone three-day AIDS awareness training in 11 districts 250 healers have been trained (four-year programme) in eight districts since 1993 60 healers have been trained as trainers of fellow healers 311 healers have been trained by fellow healers Traditional healers have gained knowledge in HIV and STI transmission, prevention and care Healers have gained counselling, teaching, leadership and record-keeping skills Trained healers provide regular community AIDS education (reaching about 650 community members every quarter, per district) Trained healers provide counselling (reaching about 100 clients per quarter, per district) Healers educate about and distribute condoms (about 150 boxes/year) Functioning referral system exists between healers and biomedical health practitioners with referral forms (about 60 clients referred from healers every quarter, per district) THETA produces a newsletter, initiated speakers' bureau, hosts a library on traditional medicine and AIDS, and produced two videos, as well as publications and scientific presentations THETA completed clinical research on the effectiveness of herbal therapies for treatment of opportunistic infections THETA developed a herbal processing and packaging demonstration lab for opportunistic infection treatments found effective THETA created and maintains a herbal garden 	<ul style="list-style-type: none"> Agreement signed with MoH Mutual respect is emphasized from the beginning Patient confidentiality is emphasized in training programmes Healers have worked within the hospital for herbal study Research participants signed informed consent Research results are systematically fed back to healers and community 	<ul style="list-style-type: none"> Cost of THETA programme ranges between US\$0.24 and US\$0.71 per healer client reached Training programme costs US\$21/day per healer trained Estimated number of beneficiaries ranges between 150 000 and 400 000 per year Administration tightly controlled and reports produced quarterly Accounts regularly audited 	<ul style="list-style-type: none"> Instead of multiplying THETA branches, strong links are built with community leaders in each district to support healer activities Healers involved in training have formed their own associations that undertake various activities including community AIDS education and drama, training of fellow healers, and PLWHA support groups. Some have received their own funding Some THETA-trained healers are involved in national policy bodies (National Drug Authority) Healers do not receive salaries, allowances or monetary incentives while training or collaborating with THETA

THETA'S SPECIFIC CRITERIA/APPROACH FOR TRADITIONAL MEDICINE/BIOMEDICINE COLLABORATION

Criteria for selecting healers	Approach used to build trust with healers	Approach used to involve biomedical health practitioners
<ul style="list-style-type: none"> Being recognized as healers by their community and local authorities Having regular patient attendance Having a clinic or shrine at which to receive and treat patients Knowing how to prepare herbal remedies using indigenous knowledge and skills to diagnose, treat and heal patients Questionnaire answered by each healer 	<ul style="list-style-type: none"> Emphasis is placed on healers' right to ownership of their treatments Initial contact with traditional healers was made through the Culture Officer of the Ministry of Gender and Community development, as well as through a TASO doctor and personal visits to the traditional healer's clinic Mutual respect is emphasized at all times Traditional healers sit on THETA Board of Trustees 	<ul style="list-style-type: none"> Biomedical health practitioners are involved in facilitating healer training THETA organizes training sessions aimed at biomedical health practitioners Biomedical health practitioners are invited to THETA speakers' bureau sessions with healers and PLWHA

VI. CONCLUSIONS AND A CALL FOR ACTION

As one traditional healer exclaimed upon learning about AIDS and its impact in Uganda, “*We had no choice but to start educating our communities*”.

Traditional healers feel a tremendous responsibility for the health of their communities as they are trusted and called upon for help in a variety of capacities. This sense of responsibility, with added skills and knowledge, has inspired traditional healers to initiate an enormous diversity of health promoting activities in their communities—largely relating, but not limited, to AIDS and STIs. Different settings have lent themselves to different responses. For example, one healer in Kampala, seeing a tremendous need, set up a school for orphans in his community after participating in a THETA training programme. The situation in Tanga lent itself to a comprehensive response based on herbal medicine provided by one traditional healer, but expanded to include a home-based care project and an educational component that addresses the high level of stigma still prevalent in rural Tanzania. In Nairobi, the issue of gender imbalance, as well as the rejection and marginalization of women infected with HIV, motivated healers to set up a programme to help infected and affected women cope with their situation with an economically feasible treatment option.

These three programmes have demonstrated an enormous capacity for care on the part of traditional healers. They have opened a very important dialogue to bridge the worlds of traditional and modern medicine. The benefits, formerly unmeasured in the realm of HIV and AIDS, are far-reaching for both in terms of prevention of HIV and for care of PLWHA, their families and community members. As one Ugandan healer explained, when a client comes to him with information about AIDS from a doctor or nurse, if the patient then receives similar information from the healer, he/she will then harbour no doubt and will be more readily able to act on that information. At the same time, stigma is significantly reduced when healers, who are highly influential community leaders, become champions of the cause. Thus, healers can significantly contribute to changes in attitude, behaviour and practices in society with respect to AIDS, people living with AIDS and traditional medicine.

Though extremely encouraging, these three initiatives are only very small islands in a vast sea of need. The current devastation caused by the AIDS epidemic in sub-Saharan Africa points to an unprecedented urgency for governments, NGOs, communities, families and individuals to act. The collaboration undertaken by these projects is one avenue that suggests a potential for reaching large numbers of people who otherwise would have very little access to prevention and care services. All three examples show that, with little input, programmes of this type could scale up to the national and regional levels and have the capacity to bring culturally and socially appropriate AIDS information and cost-effective treatment to isolated rural people in much of sub-Saharan Africa.

VII. REFERENCES AND FURTHER READING

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The Joint United Nations Programme on HIV/AIDS (UNAIDS) is the leading advocate for global action on HIV/AIDS. It brings together eight United Nations agencies in a common effort to fight the epidemic: the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations International Drug Control Programme (UNDCP), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO) and the World Bank.

UNAIDS both mobilizes the responses to the epidemic of its eight cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV on all fronts: medical, public health, social, economic, cultural, political and human rights. UNAIDS works with a broad range of partners—governmental and NGO, business, scientific and lay—to share knowledge, skills and best practice across boundaries.

In many African countries, traditional healers far outnumber modern health practitioners, and the majority of the population use traditional medicine. There has been much scepticism about traditional healers but, as this report shows, they can play a prominent role in caring for people living with HIV/AIDS as well as in prevention activities. Many traditional healers are willing to collaborate with conventional health practitioners, sharing their patients' histories and their knowledge about local treatment options.

This report describes three initiatives—in Kenya, the United Republic of Tanzania and Uganda—that have narrowed the gap between the traditional and biomedical health systems. In the Kenyan and Tanzanian projects, a traditional medicine component is integrated into more comprehensive HIV/AIDS prevention and care programmes, while the Ugandan project has dedicated itself entirely to building collaboration between traditional and biomedical healing systems for AIDS.

The report also includes anecdotal accounts by traditional healers themselves, as well as details of training provided to the healers, and lessons learned from each of the three initiatives.



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